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Pennsylvania Medicine

Vol. 81, No. 1 JANUARY 1978

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Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

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Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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INSURANCE COMPANY BOARD TO EXPAND The Board of Directors of the Pennsylvania Medical Society Professional Liability Insurance Company (PMSLIC) has recommended to the Society's Board of Trustees that the PMSLIC Board be expanded to provide wider representation. The Society's Board will consider the recommendation at its January 18 meeting. At its December 14 meeting the PMSLIC Board also gave final approval to rates for the new company. They have been filed with the Insurance Department and generally are 10 percent lower than current Argonaut rates. The department is expected to give approval. A summary of PMSLIC activities appears on page 6 of this issue.

NO CAT FUND SURCHARGE IN 1978 There will be no Catastrophe Loss Fund surcharge to Pennsylvania's health care providers in 1978. The State Society was successful in its efforts to have the Commonwealth live up to the letter of the law, in this case Act 111 of 1975. The Act provides that the surcharge on malpractice insurance premiums be waived whenever the Cat Fund exceeds $15 million. Since the fund now has in excess of $17 million, the Insurance Department approved a recommendation by the fund's director, William K. Myrtetus, to waive the surcharge. The fund covers settlements of over $100,000 resulting from medical malpractice claims. A saving of $10 million to health care providers is projected.

NEW HOSPITAL REGULATIONS PUBLISHED Final regulations governing the licensing of hospitals in Pennsylvania were published in the Pennsylvania Bulletin December 10. The Department of Health worked five years on revising the regulations which were last promulgated in 1966. The State Society was involved from the beginning in presenting the position of physicians as the rules were modernized. A limited number of copies of the final regulations are available on request from the Society, which mailed copies immediately upon publication to county medical societies and presidents and secretaries of hospital medical staffs across the state.

DR. ROWLAND CANDIDATE FOR AMA BOARD With the unanimous support of the PMS Board and the Delegation to the AMA, George A. Rowland, M.D., Millville family physician and chairman of the State Society's Board, has launched his campaign for election to the AMA Board of Trustees. The formal announcement came at the AMA's Clinical Convention in Chicago the first week in December. Dr. Rowland has held a number of leadership positions in organized medicine. In addition to his State Society activities, he has served the American Academy of Family Physicians in a number of capacities, including chairman of the Committee on Medical Education and vice president.

HEW SUPPORTS SECOND OPINIONS IN SURGERY The Department of Health, Education, and Welfare (HEW) is urging second and even third opinions on elective surgery and will pay for such opinions for its beneficiaries. HEW Undersecretary Hale Champion outlined HEW's effort at a hearing of the House Subcommittee on Oversight and Investigations in November. Carriers for medicare and medicaid will pay for patient-initiated second opinions on the need for surgery, and will pay for a third opinion if the first and second physicians' opinions are at variance. Champion said the department would monitor the program closely to determine the effect on the amount of surgery performed, and would report back to the committee in six months.

GENERIC DRUG FORMULARY FINALIZED The Department of Health published its Generic Drug Formulary in the Pennsylvania Bulletin December 10. It lists 575 drugs and combinations for use in the implementation of Pennsylvania's Generic Drug Act. The State Society's Commission on Therapeutics has

monitored the development of the formulary and advised the department during its preparation. Physicians may obtain a copy of the formulary by writing to the Department of Health, P.O. Box 90, Harrisburg, Pennsylvania, 17120, or by calling toll-free 1-800-692-7254.

ABRAMS RECOMMENDS 50% CUT IN ARBITRATION FEE Paul F. Abrams, administrator of Arbitration Panels for Health Care, has recommended a 50 percent reduction in the fee paid by doctors to support the malpractice act arbitration system. The cut to $25 would apply to doctors of medicine, osteopathy, and podiatry, but not to hospitals and primary health centers. The State Society will seek the necessary amendment to Act 111 on the reduction, which will amount to a $500,000 annual saving.

CONTINUING EDUCATION A MUST FOR INSURANCE Effective January 1, 1978, companies writing medical malpractice insurance in Pennsylvania must have a risk management plan including a continuing education requirement for insureds. Details were outlined in Insurance Department regulations. Provisions include the following requirements of insureds for policies written after January 1: conforming with the Medical Practice Act of 1974, complying with Professional Standards Review Organizations, and fulfilling the continuing education requirement of the Pennsylvania Medical Society or the equivalent thereof.

SENATE PASSES SOCIETY BACKED BILL The State Senate has passed by a vote of 38 to 0 a bill offering Catastrophe Loss Fund coverage to professional corporations. The State Society is sponsoring the amendment to Act 111 of 1975. It has been referred to the House Insurance Committee.

HEALTH DEPARTMENT ISOLATES A/TEXAS VIRUS Secretary of Health Leonard Bachman, M.D., announced December 21 that the Bureau of Laboratories had isolated and identified the A/Texas influenza virus in the Commonwealth. The first specimens in which the virus was confirmed were from Bucks and Montgomery Counties. A/Texas influenza was recognized earlier in 1977 in New Jersey and Wisconsin. Symptoms are fever, headache, muscle pains, cough, and nasal discharge of from three to five days duration.

HSA IN PHILADELPHIA TARGET OF SUIT Five county medical societies, Philadelphia, Bucks, Chester, Delaware, and Montgomery, filed suit December 7 in U.S. District Court to block the Health Systems Agency of Southeastern Pennsylvania from spending a $1.7 million federal grant. The suit charges there is improper representation on the HSA governing board. Joining the medical societies in the suit are local governments, including the city of Philadelphia, county councils of the AFL-CIO, and other professional provider groups. The HSA appointed by the U.S. Department of Health, Education, and Welfare, also a defendant, covers the five-county area. The area at one time was divided into three separate Health Service Areas. The State Society's Board of Trustees contributed $10,000 in support of the county medical societies.

PMS BREAKS EVEN IN CHICAGO The AMA House of Delegates gave approval to three of the Pennsylvania Delegation's resolutions and defeated three at its Chicago meeting early in December. Adopted was a resolution asking the AMA Board to develop a proposal providing legal advice for reference committees. Adopted after amendment was a call for a feasibility study to determine whether the AMA could undertake an evaluation of the effectiveness of community mental health centers. Referred to the Board of Trustees was a resolution on product safety and manufacturer's liability. Three resolutions on quackery were defeated. They sought to activate the AMA Committee on Quackery, establish a Quackery Defense Fund, and reactivate the AMA Investigation Committee.

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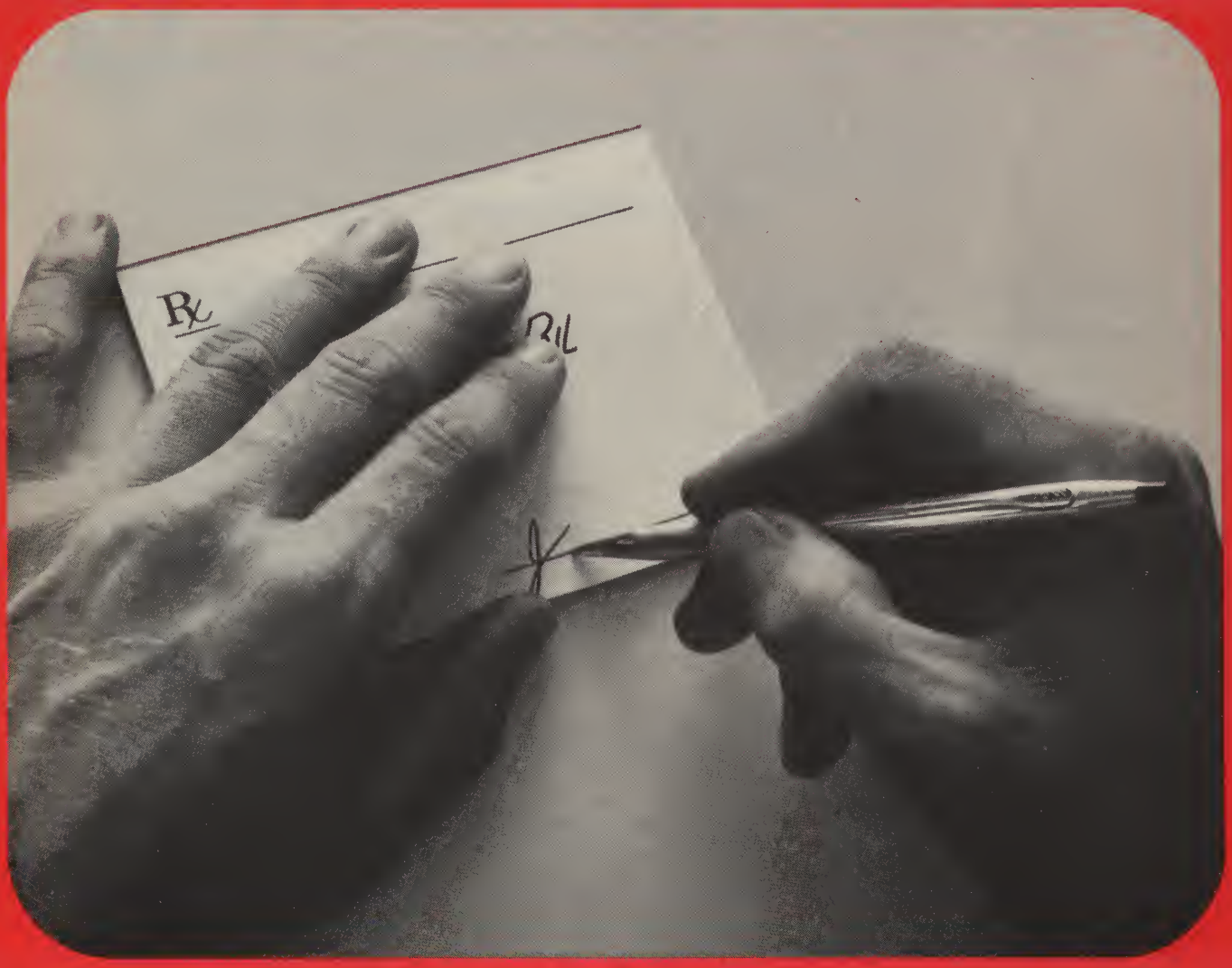
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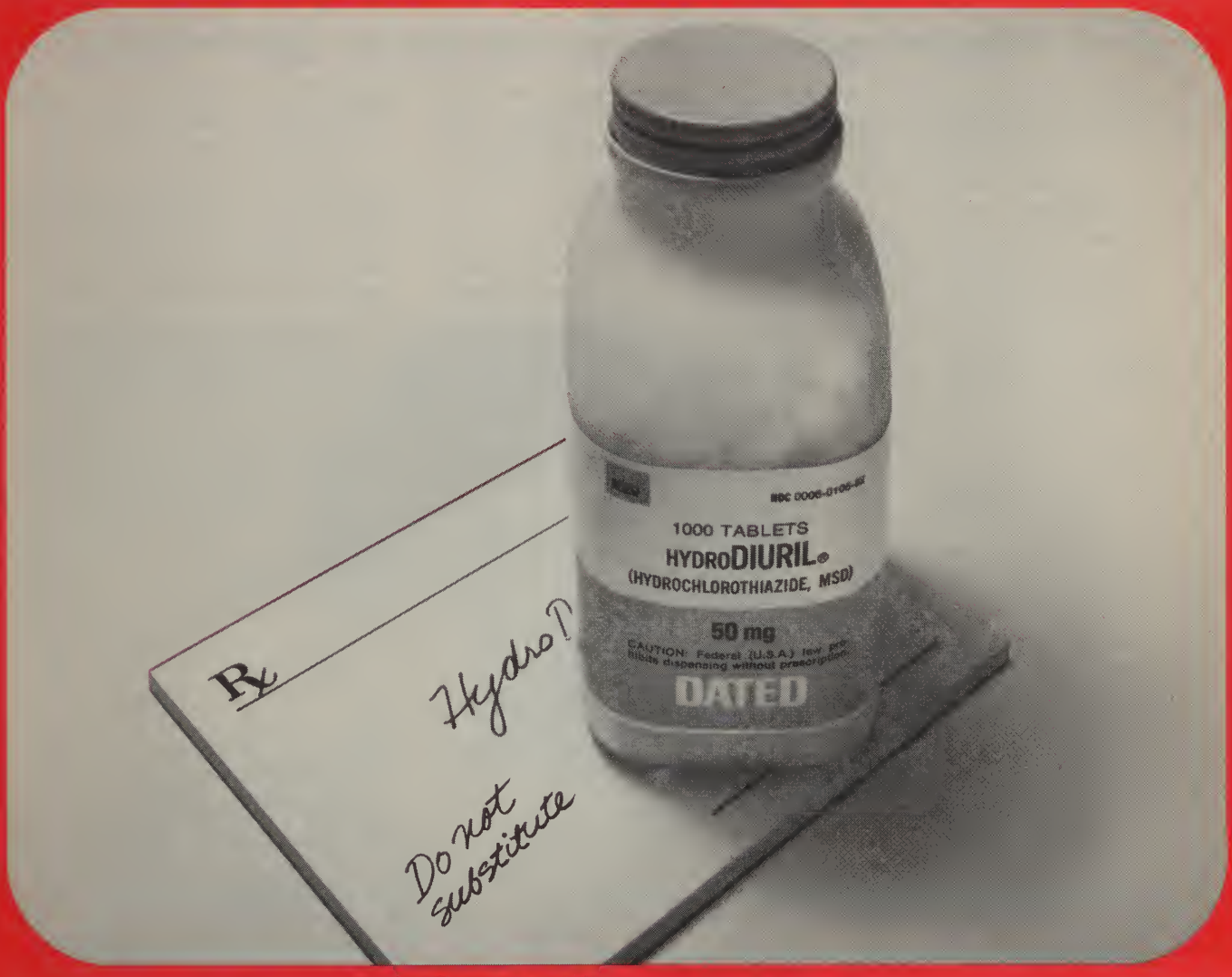
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Contraindications: Anuria; hypersensitivity to this or other sulfonamide-derived drugs.
Warnings: Use with caution in severe renal disease. In patients with renal disease, thiazides may precipitate azotemia. Cumulative effects may develop in patients with impaired renal function. Use with caution in patients with impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte balance may precipitate hepatic coma. May add to or potentiate action of other antihypertensive drugs; potentiation occurs with ganglionic or peripheral adrenergic blocking drugs. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possibility of exacerbation or activation of systemic lupus erythematosus has been reported. Lithium generally should not be given with diuretics because they reduce its renal clearance and add a high risk of lithium toxicity. Read circulars for lithium preparations before use of such concomitant therapy. *Use in Pregnancy:* Thiazides cross placental barrier and appear in cord blood; in pregnancy, weigh anticipated benefit against possible hazards to fetus, including fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions that have occurred in adults. *Nursing Mothers:* Thiazides appear in breast milk; if use of drug is deemed essential, patient should stop nursing.
Precautions: Perform periodic determination of serum electrolytes to detect possible electrolyte imbalance. Observe all patients for clinical signs of fluid or electrolyte imbalance, namely, hyponatremia, hypochloremic alkalosis, and hypokalemia. Serum and urine electrolyte determinations are particularly important when patient is vomiting excessively or receiving parenteral fluids. Medication such as digitalis may also influence serum electrolytes. Warning signs, irrespective of cause, are dryness of mouth, thirst, weakness, lethargy, drowsiness, restlessness, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbances such as nausea and vomiting. Hypokalemia may develop, especially with brisk diuresis, in severe cirrhosis, with concomitant corticosteroid or ACTH therapy, or with inadequate oral electrolyte intake. Hypokalemia can sensitize or exaggerate response of heart to toxic effects of digitalis (e.g., increased ventricular irritability). Hypokalemia may be avoided or treated by use of potassium supplements, such as foods with a high potassium content. Any chloride deficit is generally mild and usually does not require specific treatment except under extraordinary circumstances (as in liver disease or renal disease). Dilutional hyponatremia may occur in edematous patients in hot weather; appropriate therapy is water restriction, rather than administration of salt except in rare instances when the hyponatremia is life threatening. In actual salt depletion, appropriate replacement is the therapy of choice.
Hyperuricemia may occur or frank gout may be precipitated in certain patients. Insulin requirements in diabetic patients may be increased, decreased, or unchanged; latent diabetes mellitus may become manifest. Thiazides may increase responsiveness to tubocurarine. Antihypertensive effects of the drug may be enhanced in post-sympathectomy patients. May decrease arterial responsiveness to norepinephrine; this diminution is not sufficient to preclude effectiveness of the pressor agent for therapeutic use. If progressive renal im-

for experience—



or ours.

pairment becomes evident, consider withholding or discontinuing diuretic therapy. Thiazides may decrease serum PBI levels without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. Pathologic changes in the parathyroid gland with hypercalcemia and hypophosphatemia have been observed in a few patients on prolonged therapy; thiazides should be discontinued before testing for parathyroid function.

Adverse Reactions: *Gastrointestinal System*—Anorexia; gastric irritation; nausea; vomiting; cramping; diarrhea; constipation; jaundice (intrahepatic cholestatic jaundice); pancreatitis; sialadenitis.
Central Nervous System—Dizziness; vertigo; paresthesias; headache; xanthopsia.
Hematologic—Leukopenia; agranulocytosis; thrombocytopenia; aplastic anemia.
Cardiovascular—Orthostatic hypotension (may be aggravated by alcohol, barbiturates, or narcotics).
Hypersensitivity—Purpura; photosensitivity; rash; urticaria; necrotizing angiitis (vasculitis) (cutaneous vasculitis); fever; respiratory distress including pneumonitis; anaphylactic reactions.
Other—Hyperglycemia; glycosuria; hyperuricemia; muscle spasm; weakness; restlessness; transient blurred vision.
Whenever adverse reactions are moderate or severe, thiazide dosage should be reduced or therapy withdrawn.

Note: When used with other antihypertensive drugs, careful observations for changes in blood pressure must be made, especially during initial therapy. Dosage of other antihypertensive agents must be reduced by at least 50 percent as soon as this drug is added to the regimen. As blood pressure falls under the potentiating effect of this agent, further reduction in dosage, or even discontinuation, of other antihypertensive drugs may be necessary.

How Supplied: Tablets containing 25 mg hydrochlorothiazide each in bottles of 100 and 1000 and single-unit packages of 100; Tablets containing 50 mg hydrochlorothiazide each in bottles of 100, 1000, and 5000 and single-unit packages of 100; Tablets containing 100 mg hydrochlorothiazide each in bottles of 100.

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Society's insurance company activated; agreement

The Pennsylvania Medical Society's long-term solution to providing a free market for physicians to obtain malpractice insurance is a reality.

On December 1, attorneys for the Society, Argonaut Insurance Co., and Frank B. Hall and Co. met in Philadelphia to complete the settlement agreement reached September 15. It substitutes the Pennsylvania Medical Society Liability Insurance Company (PMSLIC) for Argonaut in the master contract through which the Society had kept Argonaut in the business of writing medical malpractice insurance in Pennsylvania at a time when almost all other underwriters were leaving the state. Some 4,800 physicians had malpractice insurance with Argonaut through the agreement.

Terms of the agreement also brought to an end all lawsuits brought during the period when litigation was required to force Argonaut to live up to the terms of its contract with the Society which would have expired May 31, 1979.

The completion of the settlement agreement was made possible by the raising of more than $7 million to capitalize PMSLIC through assessments on the Society's members.

As soon as adequate funding was assured for PMSLIC, Insurance Commissioner William J. Sheppard issued a certificate of authority to PMSLIC to write coverage as of January 1, 1978.

Physicians whose professional liability insurance was with the California company received applications for coverage from PMSLIC during December. Those who intended to apply also paid a selective assessment in an amount based on their risk classifications, in addition to the mandatory assessment levied on the entire membership of the Society. The money raised by these assessments made the activation of PMSLIC possible.

The alternative would have been action by Commissioner Sheppard to declare the Joint Underwriting Association (JUA) the exclusive source for professional liability coverage for physicians in the Commonwealth—an action designed to guarantee coverage for physicians in high risk categories when the free market



State implements law for education of handicapped

The Education for ALL Handicapped Children Act (Public Law 94-142), enacted by Congress in November 1975, requires that a free, appropriate public education be provided for all handicapped children between the ages of 3 and 18 by September 1978. An individualized educational program (IEP) will be developed for each handicapped child and carried out in the "least restrictive environment" possible.

Before special education services are provided, children must be evaluated and verified as handicapped. Project CONNECT, a state support system, helps intermediate units carry out the Commonwealth's Childfind activity. Physicians who think a child has a handicap should refer the parents to the CONNECT information service number—800-692-7288—for referral to the appropriate local program.

reached with Argonaut averting future crises

for them disappears. An exclusive JUA would force the Medical Protective Co. out of business in Pennsylvania, causing its several thousand insureds to seek JUA coverage. The commissioner's authority to take such action was written into Act 111 of 1975, and can be invoked when 50 percent of physicians in the high risk categories cannot find coverage in the free market. PMSLIC provides such coverage.

Over 80 percent of the Society's members responded almost immediately to the call for prompt payment of the assessments, making PMSLIC a reality. Additional billings have gone to those who did not respond by the deadline of November 15, after which those who had not paid were listed as delinquent. On January 15, 1978, notices of termination of membership effective February 15, 1978 will be mailed to all members who have not paid. The mandatory assessment is $250 for active members; $125 for senior actives; and $25 for residents. Non-dues paying members (affiliate, associate, military, and disabled) are not required to pay the assessment.

The PMSLIC Board of Directors has named Donald J. Fager Associates of New York City to carry out the day to day operations of PMSLIC. The firm, which manages the insurance company of the Medical Society of the State of New York, has established offices in Philadelphia. Questions about the assessment and PMSLIC should be directed to PMSLIC, Suite 1728, Fidelity Building, 123 S. Broad St., Philadelphia, PA 19109. Telephone (215) 545-6600.

Plastic surgeons elect Dr. Randall

Peter Randall, M.D., Philadelphia, was recently elected president of the American Society of Plastic and Reconstructive Surgery at its 46th annual convention in San Francisco.

Dr. Randall is professor of plastic surgery at the University of Pennsylvania School of Medicine, chief of the division of plastic surgery at Children's and Lankenau hospitals, and director of the facial reconstruction center at Children's Hospital.

The new ASPRS president has been a member of the society since 1955 and since 1966 has served successively as the society's general secretary (1966-69), board member (1971-72), vice president (1975-76), and president elect (1976-77). He served as president of the ASPRS Educational Foundation in 1972-73.

He is also vice president of the American Board of Plastic Surgery and a member of the Residency Review Committee for Plastic Surgery.

Dr. Randall is a founder of the Plastic Surgery Research Council, and Robert H. Ivy Society for Plastic and Reconstructive Surgery, and the plastic surgery section of the *Cleft Palate Journal,* and is past president of the American Cleft Palate Association and the American Cleft Palate Educational Foundation. He received the American Cleft Palate Association Service Award in 1974.

Blue Shield suspends participating M.D.

The Pennsylvania Department of Health released on November 7 the name of a Blue Shield participating doctor suspended for improper activities.

Stanford E. Bazilian, M.D., Philadelphia, pleaded nolo contendere in two separate cases to ten counts of fraud and two counts of bribery of a government employe and conspiracy. He was sentenced to one-year and five-year prison terms (both suspended) and fines of $1,000 and $30,000. Blue Shield suspended him for a period of at least one year or until such time as he reapplies and is accepted for registration as a participating doctor.

State Secretary of Health Leonard Bachman, M.D., said the department's approval of the suspension comes in an effort to control fraudulent or inflated patient billings. He has referred his decision and order to the State Board of Medical Education and Licensure.

Society program benefit announced

The Pennsylvania Medical Trust Group Life Insurance Program has announced a dividend of 19.8 percent to State Society policyholders for the policy year ending April 30, 1977. Since the plan was instituted in 1970, Society members have received two rate reductions and three dividends. The dividend last year was 11.45 percent.

A comprehensive report entitled "Legionnaires' Disease: Preliminary Report on its Diagnosis, Etiology, Pathology, and Therapy" issued by the Federal Center for Disease Control on September 1, 1977 and transmitted to all state and territorial public health directors and epidemiologists is now available on request from: Roslyn Q. Robinson, Ph.D., Director, Bureau of Laboratories, Center for Disease Control, Atlanta, GA 30333.

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(potassium gluconate)

Kaon® Tabs
(potassium gluconate)

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Kaon Tablets/Kaon Elixir

KAON® (potassium gluconate) TABLETS

Description: Each sugar-coated tablet supplies 5 mEq. of elemental potassium (as potassium gluconate 1.17 Gm.). Kaon Tablets are sugar coated, not enteric coated, which favors dissolution in the stomach and absorption before reaching the small intestine where the lesions with enteric potassium chloride have occurred. The sugar coating merely adds to palatability and ease of swallowing, not to delay absorption as does the enteric coating.
Indications: Oral potassium therapy for the prevention and treatment of hypokalemia which may occur secondary to diuretic or corticosteroid administration. It may be used in the treatment of cardiac arrhythmias due to digitalis intoxication.
Contraindications: Severe renal impairment with oliguria or azotemia, untreated Addison's disease, adynamia episodica hereditaria, acute dehydration, heat cramps and hyperkalemia from any cause.
Warning: There have been several reports, published and unpublished, concerning nonspecific small-bowel lesions consisting of stenosis, with or without ulceration, associated with the administration of enteric-coated potassium tablets alone or when they are used with nonenteric-coated thiazides or certain other oral diuretics. These small-bowel lesions have caused obstruction, hemorrhage and perforation. Surgery was frequently required and deaths have occurred. Available information tends to implicate enteric-coated potassium salts, although lesions of this type also occur spontaneously. Therefore, coated potassium-containing formulations should be administered only when indicated and should be discontinued immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur. Coated potassium tablets should be used only when adequate dietary supplementation is not practical.
Precautions: In response to a rise in the concentration of body potassium, renal excretion of the ion is increased. With normal kidney function, it is difficult, therefore, to produce potassium intoxication by oral administration. However, potassium supplements must be administered with caution, since the amount of the deficiency or daily dosage is not accurately known. Frequent checks of the clinical status of the patient, and periodic ECG and/or serum potassium levels should be made. High serum concentra-

1954
1977

Time is the test of all things



tions of potassium ion may cause death through cardiac depression, arrhythmias or arrest. This drug should be used with caution in the presence of cardiac disease.

In hypokalemic states, especially in patients on a salt-free diet, hypochloremic alkalosis is a possibility that may require chloride as well as potassium supplementation. In these circumstances, Kaon (potassium gluconate) should be supplemented with chloride. Ammonium chloride is an excellent source of chloride ion (18.7 mEq. per Gram), but it should not be used in patients with hepatic cirrhosis where ammonium salts are contraindicated. Other sources for chloride are sodium chloride and Diluted Hydrochloric Acid, U.S.P.

It should also be kept in mind that ammonium cycle cation exchange resin, sometimes used to treat hyperkalemia, should not be administered to patients with hepatic cirrhosis.

Adverse Reactions: Nausea, vomiting, diarrhea and abdominal discomfort have been reported. The symptoms and signs of potassium intoxication include paresthesias of the extremities, flaccid paralysis, listlessness, mental confusion, weakness and heaviness of the legs, fall in blood pressure, cardiac arrhythmias and heart block. Hyperkalemia may exhibit the following electrocardiographic abnormalities: disappearance of the P wave, widening and slurring of QRS complex, changes of the S-T segment, tall peaked T waves, etc.

Overdosage: Potassium intoxication may result from overdosage of potassium or from therapeutic dosage in conditions stated under "Contraindications." Hyperkalemia, when detected, must be treated immediately because lethal levels can be reached in a few hours.

KAON® (potassium gluconate) ELIXIR

Description: Each 15 ml. (tablespoonful) supplies 20 mEq. of elemental potassium (as potassium gluconate, 4.68 Gm.) with saccharin and aromatics. Alcohol 5%.

Indications: See Kaon Tablets.

Precautions: See Kaon Tablets.

In hypochloremic alkalosis, potassium replacement with potassium chloride (e.g., Kaochlor® 10% Liquid) may be more advantageous than with other potassium salts.

Adverse Reactions: See Kaon Tablets.

Overdosage: See Kaon Tablets.

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Pennsylvania study group learns about

The t-shirts say "Sweden is fantastic!" and most tour members would agree—at least about some things.

Can American physicians learn from a study of health care delivery in other nations?

Participants in the Scandinavian study tour sponsored by the Council on Education and Science think they can.

The 17-member group, which toured Sweden, Norway, and Denmark from September 25 to October 3, examined the health planning and emergency health systems in each nation. Tour members spoke with physicians, hospital administrators, planners, and patients to learn about the strengths and weaknesses of national health care systems.

Although health care is organized and financed differently in each country, several general impressions prevail among group members:

• Scandinavians want security. They clearly believe in the right to health care with little out-of-pocket payment. While they appear to be satisfied with their medical care, they are overwhelmed by the taxation (most pay between 60 and 70 percent of income) that makes nationalized health care possible. Few, however, are willing to cut back medical benefits to reduce taxes.

• The philosophy of health care seems to be delivery of good general care to everyone rather than excellence of care. This emphasis on availability of good emergency and primary care has resulted in backlogging of patients not requiring immediate care and in less discretion in patient choices.

• Because most physicians are salaried government employes, the costs of overtime and compensatory time keep income high. Provider associations, both general and specialty, are strong in





health services in Scandinavian countries

Workshop participants tour the emergency unit of Sweden's famed Karolinska Institute in picture at left. Ole K. Harlem, M.D., editor of the Norwegian Medical Journal and former director of the World Health Organization, speaks to tour members William Y. Rial, M.D., and Mrs. Rial, below left, and to Abram Hostetter, M.D., Harvey Shipkovitz, M.D., Richard C. Lyons, M.D., and Burton Cohn, M.D., below. Denmark's unique emergency system provides for government contracts with a private firm (Falck), at right, for patient transport services. Falck employs 5,050 people to staff its 132 stations.





their dual role as bargaining agents and advocates on delivery issues.

One tour member suggests that there are lessons to be learned from the Scandinavian systems as the Carter administration readies its national health insurance program.

1. National health insurance should be introduced incrementally to avoid overloading the system and inflationary pressures;

2. Joint consensus planning is necessary, although it almost certainly will not follow the course chosen by the Scandinavians;

3. Physicians and medical societies should be actively involved in the planning and administration of programs;

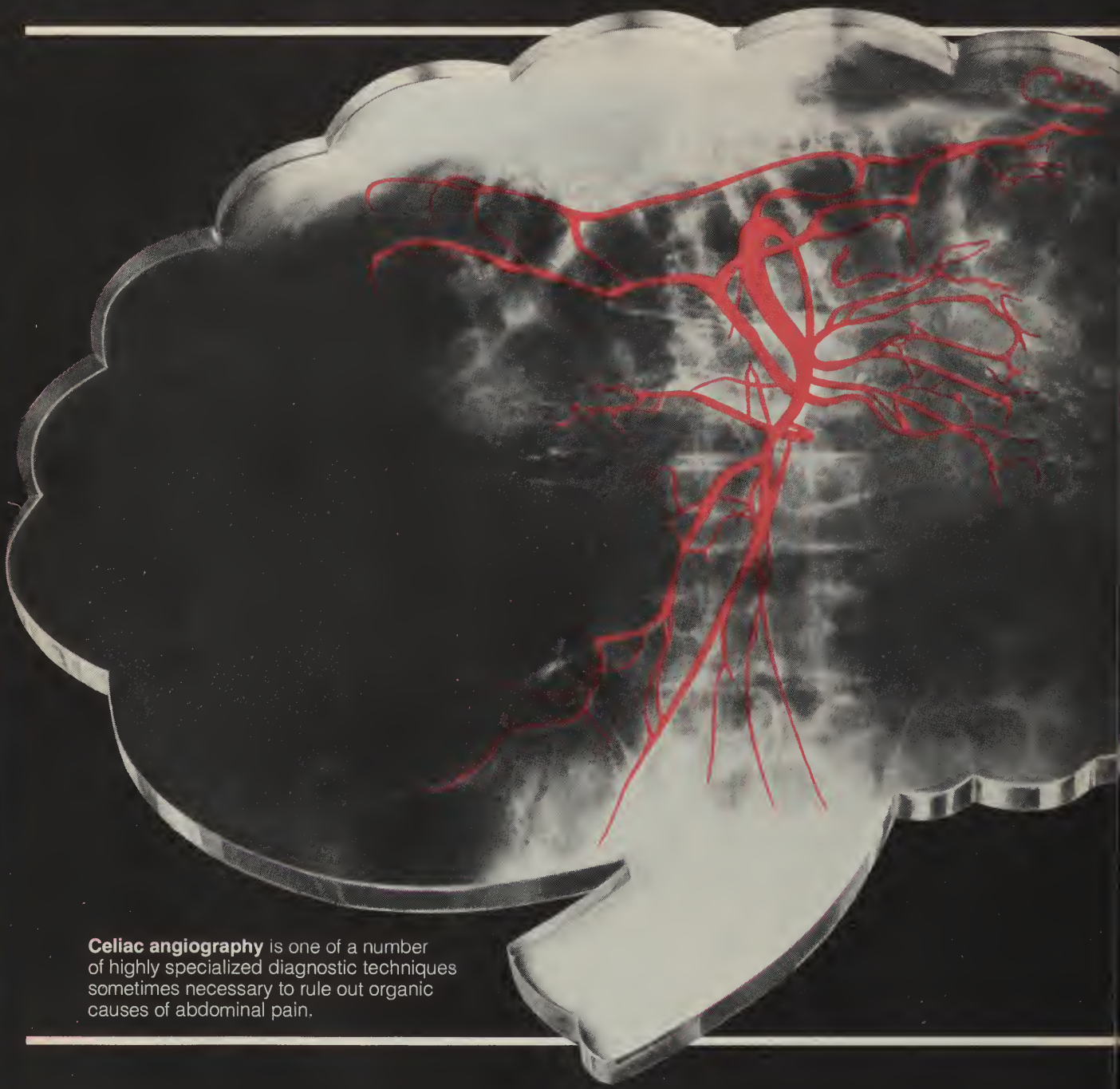
4. Administration of a national system should be at the local level, an important consideration according to Scandinavian health professionals; and

5. Primary and preventive care should be encouraged to reduce health costs.

The Scandinavian system has good and bad points, but group members agree that it provides an excellent study for health professionals who foresee a national health program in the United States.

Additional workshop tours of Scandinavia are scheduled for May 7-15 and September 24-October 2, 1978. For more information contact the Council on Education and Science, Pennsylvania Medical Society, 20 Erford Rd., Lemoyne, PA 17043.

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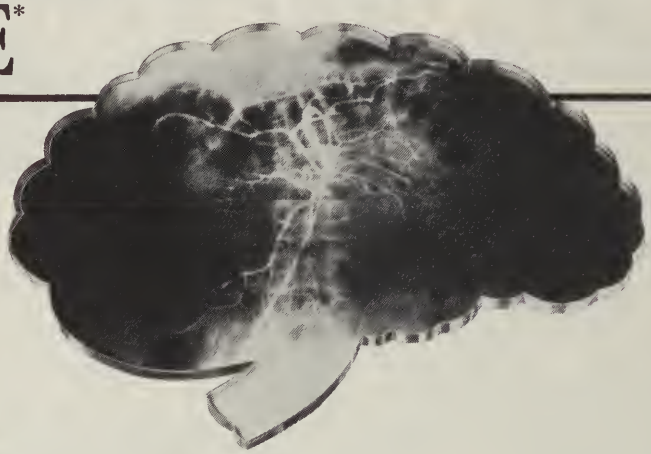
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"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.
Final classification of the less-than-effective indications requires further investigation.

Contraindications: Patients with glaucoma; prostatic hypertrophy and benign bladder neck obstruction; known hypersensitivity to chlordiazepoxide hydrochloride and/or clidinium bromide.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering Librium® (chlordiazepoxide hydrochloride) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

As with all anticholinergic drugs, an inhibiting effect on lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude development of ataxia, oversedation or confusion (not more than two capsules per day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacologic effects of agents, particularly potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: No side effects or manifestations not seen with either compound alone have been reported with Librax. When chlordiazepoxide hydrochloride is used alone, drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are avoidable in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally with chlordiazepoxide hydrochloride, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax are typical of anticholinergic agents, *i.e.*, dryness of the mouth, blurring of vision, urinary hesitancy and constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

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How Supplied: Librax is available in green capsules, each containing 5 mg chlordiazepoxide hydrochloride (Librium®) and 2.5 mg clidinium bromide (Quarzan®)—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 50, available singly and in trays of 10.

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- Protein Electrophoresis
- Quantitation of IgG, IgA, IgM

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- Alpha-1-acid glycoprotein
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- CEA
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'STUDY SCANDINAVIA'

A workshop tour of Sweden, Norway and Denmark

Scandinavian medicine holds an interest for American physicians because of technical advances in many specialties, innovative relationships with the social services, and concern for the promotion of good health. Manifestations are the infant mortality rate, one of the lowest in the world, developments in delivering emergency and outpatient services, and preventive medicine.

The workshop will give you a firsthand view of primary care, emergency services, basic research and hospital medical services. You will talk with government officials, medical and technical specialists, university professors, and doctors in local practice.

Take advantage of one of two nine-day learning experiences. Visit three major cities, Stockholm, Oslo, and Copenhagen, to learn more about the health services in the Scandinavian Countries.

May 7-15, 1978 or September 24-October 2, 1978

- Round trip jet air transportation via Scandinavian Airlines 747 with food
- All first class hotel accommodations.
- Continental breakfast daily, most lunches and dinners.
- Three days in Stockholm, two days in Oslo, three days in Copenhagen.
- Overnight train trip to Copenhagen.
- Guided orientation and cultural tour in each country.
- Only 20 individuals on each workshop tour.
- 10 hours Category I credit for PMS-CME membership requirement.

Cost - $980 per person, double occupancy

This travel program meets all the "guidelines for foreign convention tax expense" under the Tax Reform Act of 1976 as interpreted by the American Society of Association Executives. Under the new law, deductions can be allowed for expenses incurred in foreign travel. The limits are air fare and per diem allowances. The workshop tour can also be considered as a deduction for education to maintain and improve skills required in a trade or business. Complete attendance records and other tax deduction information will be furnished so that member physicians can consult with their accountants for deductions on individual tax returns. For full itinerary and full tax information, write to Council on Education and Science, Pennsylvania Medical Society, 20 Erford Road, Lemoyne, Pennsylvania, 17043, using the application below.

Council on Education and Science
Pennsylvania Medical Society, 20 Erford Road, Lemoyne, PA 17043

Please send me full details on the Study Scandinavia Workshop

Indicate which workshop tour interests you: ☐ May 7-15, 1978
☐ Sept. 24-Oct. 2, 1978

Name: _____

Address: _____

Telephone: _____

Legal counsel reports status of countersuits

The status of malpractice countersuits brought by Pennsylvania Medical Society members is reviewed in a recent report from legal counsel to the PMS Board of Trustees.

Of 55 cases reviewed, two suits have been instituted as a result of the Society's ongoing policy of supporting justifiable suits for malicious use of civil process.

The full text of the report follows.

"At the direction of the Board of Trustees and Councilors, the Pennsylvania Medical Society's Ad Hoc Committee on Medical Malpractice Insurance with the aid of legal counsel has reviewed 55 medical malpractice suits against physicians. To date two members of the Pennsylvania Medical Society have instituted actions for malicious use of civil process (countersuits).

"In one suit a Complaint has been filed and the defendant attorneys have filed Preliminary Objections contending, among other things, that the countersuit does not properly lie because under Pennsylvania law an indispensable element of the tort of malicious use of civl process is that the physician must have been arrested or his property seized. This legal issue must be resolved by the Trial Court or Appellate Court before the case may be tried on the merits.

"A second countersuit has been instituted by a member of the Pennsylvania Medical Society. Prior to filing a Complaint the physician had attempted to discover the defendant attorney's file in an endeavor to establish whether the defendant attorney properly investigated the merits of the malpractice suit before it was instituted. The defendant has filed Preliminary Objections and the Trial Court or Appellate Courts must decide whether the defendant attorney's file is discoverable or protected by the doctrines of "privilege" or "work product" of counsel made in anticipation of litigation.

"The Society will continue to review additional malpractice suits submitted by members who have been sued."

Heart affiliate selects officers

John S. Chaffee, M.D., Erie, was installed as the 28th president of the American Heart Association, Pennsylvania Affiliate, at the recent annual assembly in Harrisburg.

Dr. Chaffee, attending surgeon at Erie's Hamot Medical Center, has served as president of the northwestern chapter, vice chairman of the Affiliate exercise committee, and a member of its central program and public health education committees.

Dr. Chaffee was installed by the outgoing president, Lawrence N. Adler, M.D., Pittsburgh, who received a distinguished service medallion for outstanding leadership.

Stephen B. Langfeld, M.D., of Philadelphia was named president elect and will take office next September. Dr. Langfeld is director of the University Office for Planning Health Care at Thomas Jefferson University. He has been active at the Affiliate level since 1964, also serving as vice president and a member of its board and executive committee.

The three new vice presidents are: Robert F. Zelis, M.D., Hershey, chief of the division of cardiology at The Pennsylvania State University College of Medicine and president of the American Federation for Clinical Research; William J. Kimber, M.D., Danville, associate in cardiology at Geisinger Medical Center and past president of the northcentral Pennsylvania chapter; and Robert C. Magley, M.D., Ebensburg, a family practitioner on the staff of Miners Hospital of Northern Cambria and a past president of the Pennsylvania Highlands chapter.

Dr. Zelis will fill the position of vice president of public policy, a new post created to increase the association's role in legislative response.

Other physicians elected to the executive committee and Affiliate board of directors are: David M. Leaman, M.D., Hershey, director of the cardiac catheterization laboratory at The Pennsylvania State University College of Medicine and chairman of the Affiliate central program committee; William S. Frankl, M.D., Philadelphia, professor of medicine and director of the cardiovascular division at the Medical College of Pennsylvania; Harry Goldberg, M.D., Philadelphia, director of the cardiovascular section at Albert Einstein Medical Center; Alan C. Harter, M.D., Erie, director of industrial health services for the General Electric Company in Erie; and Joseph M. Young, M.D., Monessen, staff member at the Mon Valley Hospital, Charleroi Division.

Legal counsel reports

Court finds firing of nurse unjust, compensable

FRED SPEAKER, ESQ.
Harrisburg

A nurse may not be fired with immunity for failing to follow the doctor's orders unless the hospital is able to provide explicit evidence of willful misconduct, according to a recent decision of the Commonwealth Court.

In the matter which led to the dismissal of the nurse and two other employees, an elderly woman had been admitted to the hospital with the diagnosis of a urinary tract disorder. The woman was fitted with a Foley catheter and the physician's orders, noted on her chart, were that the catheter was to remain in place, with maintenance care, and that accurate records were to be kept of the woman's fluid intake and output.

For an unexplained reason, the orders were not followed by the nursing staff. Instead, for eighteen days the patient was placed on a schedule of bladder training. When the hospital discovered the situation, the nurse was fired.

She claimed unemployment compensation, the referee denied benefits, and the Board affirmed. The Board found that the nurse had removed the catheter without permission and had noted the patient's adverse symptoms on her chart but had failed to report them to the doctor or to her supervisor.

The nurse disputed the Board's findings, testifying that she had not removed the catheter and had followed her supervisor's orders. The hospital offered evidence only that an unnamed member of the nursing staff had removed the catheter. The Court held that there was no evidence to support the Board's finding that the defendant had removed the catheter.

The nurse also disputed the Board's finding that she was guilty of willful misconduct in not reporting the patient's condition to the doctor. The hospital representative testified that under her job description the nurse was not required to make such a report, although she was authorized to report if she thought it necessary. The Court concluded:

Under these circumstances, although the claimant here may have been guilty of bad judgment in not contacting her supervisor or the doctor and informing either or both of them as to the patient's present condition, we do not believe that her actions amounted to willful misconduct. Frick v. Unemployment Compensation Board of Review, 375 A.2d 879, 881 (Pa. Commw. Ct. 1977).

Thus the Commonwealth Court reversed the Board, essentially because the hospital fell far short of providing unequivocal evidence of the nurse's wrongdoing.

Mr. Speaker is an attorney with Pepper, Hamilton & Scheetz, legal counsel for the State Society.

Humanities seminars offered to practitioners

The National Endowment for the Humanities will continue its summer program of humanities seminars for medical practitioners in 1978.

The seminars, which meet at selected colleges and universities, will bring together physicians and other health professionals for a month of full time study under the direction of distinguished philosophers, historians, and others.

The seminars are designed to give participants the opportunity to stand back from their work and explore the humanistic dimensions of their profession by studying such topics as the history of professional ethics in American medicine, moral dilemmas in medical practice, and the relationship between individual and public rights in health care.

A second series of seminars open to health practitioners will examine ethics in contemporary life, value conflict in our society, the cultural foundations of U.S.-Asian foreign relations, individualism in American society, and contemporary religious movements.

Physicians, nurses, public health officials, hospital administrators, and other health professionals should apply by April 17, 1978. For further information contact Professions Program, Division of Fellowships, National Endowment for the Humanities, Washington, DC 20506.

Physicians and other health professionals are now required by the Pennsylvania Child Protective Service Act (124) to report suspected child abuse. Oral reports should be made to CHILDLINE-800-932-0313, or to the local county Child Protective Service Unit. A written report on form DPW CY 47 must also be submitted within 48 hours of the initial report.

State Society urges physician support for MECO

In an attempt to bring about a redistribution of Pennsylvania's physician manpower, the Pennsylvania Medical Society and the Hospital Association of Pennsylvania are sponsoring the American Medical Student Association-Medical Education and Community Orientation (MECO) Project.

The eight-week summer program allows medical students to observe primary health care in the community and to work with preceptors, hospital administrators, and other health care professionals.

The 1978 project will include many of the features that have been a part of the MECO Project since its inception in 1969. These include:

1. Scheduling of the project to suit local personnel. Participants should include: a medical student; the staff of a community hospital that is not a primary university teaching hospital; community physicians; group practice clinics; and a primary care physician who serves as preceptor.

2. Provision for room, board, and a stipend of $85 per week. While most projects last for eight weeks, this feature is flexible depending on facilities and funds.

Physicians who are interested in providing a student with a positive experience relating to medical practice in a community setting should contact the Council on Education and Science, Pennsylvania Medical Society, 20 Erford Rd., Lemoyne, PA 17043.

Orthopaedic Society elects new officers

The Pennsylvania Orthopaedic Society met in November to elect its officers for the coming year. New officers are: Marvin E. Steinberg, M.D., Philadelphia, president; William A. Steinbach, M.D., Scranton, vice president; Francis A. Lovecchio, M.D., East Stroudsburg, secretary-treasurer; Jerome A. Cotler, M.D., Philadelphia, member of the executive committee; and Martin L. Beller, M.D., Philadelphia, member of the board of councilors of the American Academy of Orthopaedic Surgeons.

Dr. Likoff new Hahnemann president

William A. Likoff, M.D., Philadelphia, was elected president and chief executive officer of Hahnemann Medical College on November 22. He had been acting president since the resignation of Wharton Shober on June 21.



DR. LIKOFF

Dr. Likoff, a leading cardiologist and a Hahnemann graduate, is a professor of medicine and director of the William Likoff Cardiovascular Institute at Hahnemann.

He is a past president of the Heart Association of Southeastern Pennsylvania, and was chairman of the National Committee on Continuing Education Programs for the American College of Cardiology. From 1972 to 1974 he was chairman of the steering committee for the Joint Commission on Accreditation of Hospital Appraisal of Quality Services in Heart Diseases.

HAP releases hospital cost figures

Pennsylvania hospitals spent an average of $142.36 to provide a day of inpatient care in 1976, according to figures released by the Hospital Association of Pennsylvania (HAP).

Commenting on the figure, HAP board chairman Clive R. Waxman, Jr., of Williamsport, said inflation, government regulation, increased public demand, and continued technological innovation are the principal reasons for rising costs.

The figure is about 15 percent higher than the average daily cost of $124.28 for 1976, but still nearly $9.50 a day less than the national average of $151.79 and lower than any of the states surrounding Pennsylvania.

For the fourth consecutive year, length of stay in Pennsylvania's hospitals decreased—this time by one-tenth of a day to 8.4 days. In 1972, the average hospital stay lasted 9.1 days.

Among other figures released in the report was the .9 percent increase in hospital occupancy in 1976, yielding a total of 78.1 percent. There were 4.5 million emergency room visits—a 6.5 percent increase over 1975—and total outpatient visits increased by 4.7 percent to nearly 16.8 million. Pennsylvania hospitals treat about nine outpatients for every patient hospitalized. The average number of employes per patient in 1976 was 3.35—up slightly from the previous year for a total of 145,732 equivalent full time employes.

editorials

Travel advisory

Travel is an educational experience and a welcome break from the pressure and strain of daily routine. But the complications of modern day travel can destroy a vacation and an individual's health. Physicians ought to be able to advise the person who is preparing to travel, and to diagnose and treat travel-related ailments should they occur. It is more important to prevent than to treat.

In general, health concerns for travel can be divided into five major areas: (1) immunizations, (2) method of transportation, (3) destination, (4) precautions regarding food and beverages, and (5) diagnosis and treatment of exotic diseases.

One of the best sources on immunization and prophylaxis is a monograph entitled "Health Information for International Travel 1977," a supplement to the *Morbidity and Mortality Weekly Report*. MMWR also publishes current reports on immunization requirements and epidemic disease outbreaks. These are available from the Center for Disease Control in Atlanta at no charge. Most state health departments also provide immunization information.

Modern high speed transportation has presented its own set of unique problems. "Jet lag," the descriptive expression applied to the disruption of normal circadian rhythm caused by rapid passage through several time zones, may produce discomforting physiological and psychological symptoms. It may require several days to adjust (or readjust) to local time zones. Motion sickness, especially during stormy weather, may occur. Barotitis has been noted, particularly in those persons with acute upper respiratory infections or previously diseased ears. Other disorders due to rapid elevation and pressure change have been reported so that specific disease conditions should be evaluated prior to long high-speed flights.

Destination becomes an important consideration when traveling to tropical climates because of sudden sun, temperature, and humidity changes as well as an increased risk of disease due to insect vectors. Malaria is endemic to most of the tropics and some strains have proven resistant to chemoprophylaxis. Travelers to these areas should follow the recommended regimen for malaria and should be informed that attacks may still occur. Several good papers on malaria have appeared in recent literature, but due to changing opinions on prophylaxis, it is best to contact the CDC for current information.

Traveler's diarrhea, which probably results from ingestion of food and beverages containing gastrointestinal pathogens, is usually a mild but annoying disease. Drug prevention has not been recommended but it is suggested that care be taken in eating and drinking practices. Food- and water-born disease is more common in countries where sanitation is poor. Meat and vegetables should be well cooked. In places where water may be contaminated, persons should be advised not to drink, use ice, or swim.

Finally, diagnosis of diseases acquired while traveling can be puzzling. Most of these entities present with fever and diarrhea, the cause of which may not be apparent. It is important to obtain an immediate past history to identify the disease and initiate treatment.

One of Ben Franklin's timeless proverbs from Poor Richard's Almanack (1755) admonishes, "He that would travel much, should eat little." While this maxim remains true today, not all modern travel maladies are food related. The physician's role in prevention cannot be overemphasized. He should be thoroughly familiar with the latest prophylactic measures and be prepared to advise his traveling patients.

Happy New Year to all, and to those who are neophytes abroad, go prepared!

David A. Smith, M.D.
Medical Editor

MDs in the news

The Board of Governors of the American College of Surgeons has elected **Henry T. Bahnson, M.D.,** professor and chairman of the department of surgery at the University of Pittsburgh School of Medicine, to a two-year term on its executive committee. Dr. Bahnson, who is also chief of surgery at Presbyterian-University Hospital, is widely known for his research in the field of cardiac surgery.

William P. Graham, III, M.D., professor of surgery and chief of plastic and reconstructive surgery at the Pennsylvania State University College of Medicine, Hershey, is co-editor of a new medical textbook, "The Hand: Surgical and Non-Surgical Management." His collaborator on the volume is Eugene S. Kilgore, Jr., M.D., of the University of California Medical School in San Francisco. The 500-page book, published in October by Lea and Febinger of Philadelphia, includes chapters by Drs. Graham and Kilgore and 19 other contributors, including **Stephen Miller, M.D.,** associate professor of surgery at Hershey.

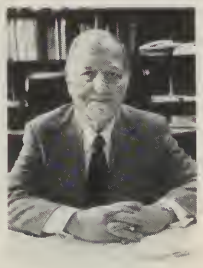
Steven D. Herman, M.D., has joined Hahnemann Medical College and Hospital of Philadelphia as assistant professor of surgery and attending surgeon in the division of cardiothoracic surgery. Also appointed to the full time staff is **Dennis J. Khoury, M.D.,** a specialist in the medical and surgical treatment of the retina and diseases of the vitreous, who will serve in Hahnemann's department of ophthalmology.

At its recent annual meeting in Quebec City, Canada, the northeastern section of the American Urological Association installed **John S. Rose, Jr., M.D.,** associate in the department of urology at Geisinger Medical Center, Danville, as its thirtieth president. The northeastern section of the AUA includes approximately 350 urologists from Pennsylvania, New York, Ontario, Quebec and the Maritime Provinces, and is one of eight in the international organization representing the United States and Canada.

Edwin D. Arsht, M.D., Drexel Hill, has been named director of the newly established department of family practice of Delaware County Memorial Hospital. Dr. Arsht, director of medical education and services, has been associated with the hospital since 1960. He is a charter member and diplomate of the American Board of Family Practice and recently passed in that specialty the first recertification examination ever given by an American specialty board. Dr. Arsht is an instructor in the department of family medicine at Jefferson Medical College and a family practice preceptor for the Pennsylvania Academy of Family Physicians and Jefferson and Hahnemann Medical Colleges.



DR. ARSHT



DR. FRANKEL

Donald S. Frankel, M.D., Oak Lane, attending obstetrician and gynecologist at the Albert Einstein Medical Center, Northern Division, was recently awarded the fifth annual Paul M. Wagner Teaching Award. The award, which is named for the chairman emeritus of the hospital's division of obstetrics and gynecology, is given by resident physicians to a member of the medical staff whom they wish to honor for dedication and excellence in the education of ob/gyn residents. Dr. Frankel also serves as an assistant professor at Temple University School of Medicine and Hahnemann Medical College.

Harold G. Scheie, M.D., founder of the Scheie Eye Institute and professor emeritus of ophthalmology at the University of Pennsylvania School of Medicine, will receive the International Glaucoma Congress Gold Medal for "most notable contributions to the fight against glaucoma blindness." The award will be presented at the annual meeting in February of the American Society of Contemporary Ophthalmology.

David J. Kupfer, M.D., professor of psychiatry and director of research at the Western Pennsylvania Psychiatric Institute and Clinic, recently traveled to Basel, Switzerland to receive the Anna Monika Foundation Prize. The award, sponsored by the German government, is given every two years to scientists who have contributed to advances in the treatment of depression. Dr. Kupfer was lauded for his ten-year study of the use of sleep patterns in the diagnosis and treatment of depression.

Jessica H. Lewis, M.D., and **James A. Shaver, M.D.,** were recently promoted to the rank of full professor of medicine at the University of Pittsburgh School of Medicine. Dr. Lewis is director of the Hemophilia Center of Western Pennsylvania and vice president of research at the Central Blood Bank of the University Health Center. She has contributed major research on blood coagulation, hepatitis, and sickle cell anemia. Dr. Shaver is director of the division of cardiology at the university and chief of cardiology at Presbyterian-University Hospital. He is a fellow of the American College of Cardiology and has been governor of its Western Pennsylvania Chapter since 1974.

The prestigious Gold Medal of the Barren Foundation has been awarded to **Luigi Mastroianni, Jr., M.D.,** chairman of the University of Pennsylvania School of Medicine's department of obstetrics and gynecology. Dr. Mastroianni serves as director of the department's division of reproductive biology, where emphasis is placed on primate research.

Leslie Nicholas, M.D., Philadelphia, has been elected president of the American Venereal Disease Association. Dr. Nicholas is professor of medicine (dermatology) at Hahnemann Medical College.

MDs in the news

New fellows of the American College of Surgeons are: **Norman L. Edelstein, M.D.,** McKeesport; **Pedro A. Salazar, M.D.,** Hazleton; **Marvin T. Hunter, M.D.,** Doylestown; **Milton R. Horwitz, M.D.,** and **Michael Jochnowitz, M.D.,** Lansdale; **Thomas W. Brown, M.D.,** Quakertown; **David C. Rilling, M.D.,** Sellersville; **Manuel Espinosa, M.D.,** Easton; **K. P. Srinivasa Prabhu, M.D.,** New Castle; **Donald L. Preate, M.D.,** Waverly; **Bruce E. Duke, M.D.,** Johnstown; **Dorothy G. Wilson, M.D.,** and **Edward V. Twiggar, M.D.,** Sunbury; **James A. Strite, M.D.,** Gettysburg; and **Pricha Boonswang, M.D.,** Wilson.

Also named to the academy are four Delaware County physicians: **Joseph L. Wilkerson, M.D.,** Drexel Hill; **Edward A. Jaeger, M.D.,** Media; **Zarko M. Vucicevic, M.D.,** Ridley Park; and **William F. Holmes, M.D.,** Wayne.

Fotis G. Mystakas, M.D., George C. Potash, M.D., Earl J. Snyder, M.D., and **Ramon U. Suarez, M.D.,** all of Lebanon, and **Robert B. Page, M.D.,** Hershey, are also new fellows of the academy.

Three Pennsylvania physicians were recently elected to fellowship in their respective specialty societies. They are: **Raymond E. Dietz, M.D.,** of Harrisburg, the American Society of Bariatric Physicians; **Peter W. Ross, Jr., M.D.,** of Shamokin, the American College of Obstetricians and Gynecologists; and **Robert L. Fry, M.D.,** of Chambersburg, the American Academy of Ophthalmology and Otolaryngology.

The American Board of Internal Medicine recently certified as diplomates the following physicians: **David C. Tsai, M.D.,** Altoona; **Riad Saradar, M.D.,** Uniontown; **Michael Patrick, M.D.,** Bethlehem; **Ronald Krablin, M.D.,** Gettysburg; **Alan D. Hoover, M.D.,** Pittsburgh; and **Stephen M. Druckman, M.D.,** Lebanon.

Also certified in their respective specialties are: **K.N.P. Krishnaraj, M.D.,** of Bloomsburg, by the American Board of Pediatrics, Inc.; and **Lee Denlinger, M.D.,** of Titusville, by the Pennsylvania Board of Internal Medicine.

Allentown Hospital recently announced the addition of three new physicians to its staff. **Robert L. McGuire, M.D.,** has returned to the hospital from private practice to become educational coordinator for the department of obstetrics and gynecology. **Joseph A. Diorio, M.D.,** has been named chief of anesthesiology, a position which he most recently held at Quakertown Hospital. **Bala Bansal, M.D.,** has been appointed associate pathologist in charge of the clinical labs and blood bank. Dr. Bansal was formerly assistant professor of pathology and director of the blood bank and hematology laboratory at the Medical College of Pennsylvania.

Rosaline R. Joseph, M.D., West Mount Airy, has been appointed professor of medicine and chief, division of hematology-oncology in the department of medicine at the Medical College of Pennsylvania, Philadelphia. She was formerly associate professor of medicine in hematology-oncology at Temple University Health Sciences Center. Dr. Joseph is a diplomate of the National Board of Medical Examiners and the American Board of Internal Medicine and a fellow of the American College of Physicians.

Geisinger Medical Center, Danville, recently announced the appointment of five new associates. **Joseph P. Colancecco, M.D.,** a graduate of Hahnemann Medical College, will serve in the department of general internal medicine. **Bakulesh Patel, M.D.,** who received his medical education at Topiwala National Medical College, Bombay, India, will work in the division of pediatric medicine. The division will also be joined by **Dolores Rodriguez, M.D.,** a specialist in pediatric neurology, and **Daniel L. Zeidner, M.D.,** a pediatric endocrinologist who is engaged in research on the growth and development of patients with Turner's Syndrome. **Kalyan S. Krishnan, M.D.,** who received his medical training at Kasturba Medical College, Manipal, India, will work in the department of anesthesiology.

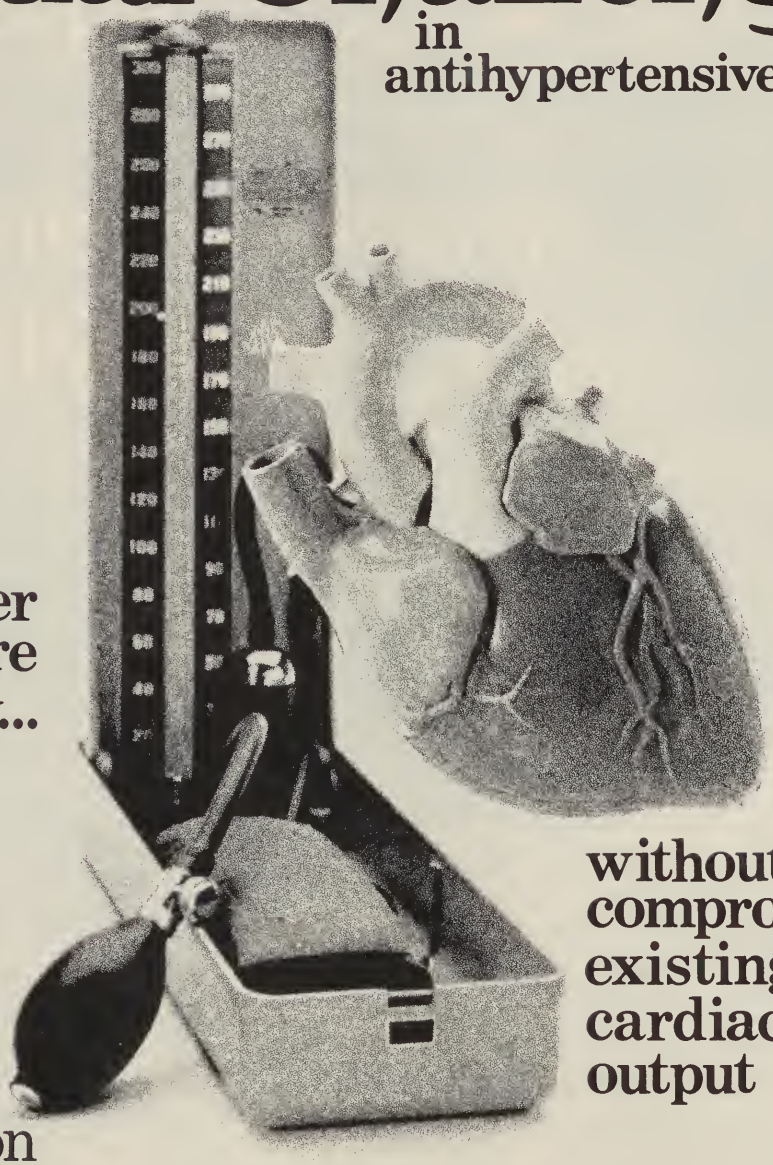
The department of anesthesiology of the Pennsylvania State University College of Medicine, Hershey, recently established two new divisions. Named to head respiratory and intensive care in the new Ambulatory Care Center is **Kermit R. Tantum, M.D.,** associate professor of anesthesiology. **Timothy Foley, M.D.,** assistant professor of anesthesiology, has been appointed clinical director of the operating rooms. Dr. Foley will supervise all operating room activities and resident physician development and training in the various clinical areas.

The staff of Harrisburg Hospital was recently joined by three new members. They are: **V. Eugene Kilmore, Jr., M.D.,** department of surgery, section of ophthalmology; **Jonathan B. Tocks, M.D.,** department of family practice; and **Naresh S. Maingi, M.D.,** department of pediatrics.

The American Academy of Family Physicians recently elected to fellowship the following physicians: **Vorrie B. Macom, M.D.,** Lansford; **W. E. Boyer, M.D.,** Oil City; **John A. Palumbo, M.D.,** Lancaster; **Brian A. Wummer, M.D.,** Womelsdorf; **Salvatore A. Lawrence, M.D.,** Dunmore; **Samuel G. Watterson, M.D.,** Jennerstown; **Henry W. Shoenthal, M.D.,** New Paris; **J. Lawrence Ginsberg, M.D.,** Lewisburg; and **Stephen C. Cenedella, M.D.,** Franklin.

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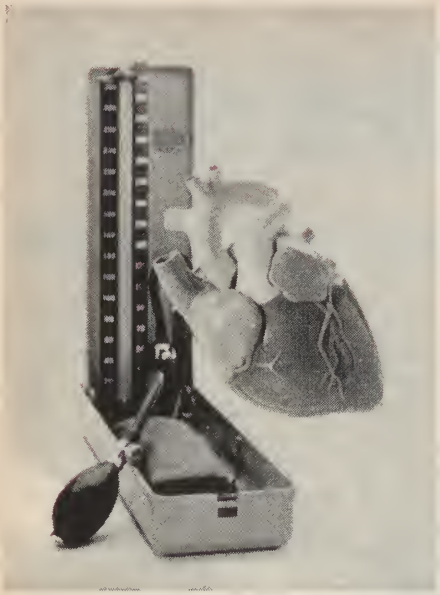
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Warnings: It is important to recognize that a positive Coombs test, hemolytic anemia, and liver disorders may occur with methyldopa therapy. The rare occurrences of hemolytic anemia or liver disorders could lead to potentially fatal complications unless properly recognized and managed. Read this section carefully to understand these reactions.

With prolonged methyldopa therapy, 10% to 20% of patients develop a positive direct Coombs test, usually between 6 and 12 months of therapy. Lowest incidence is at daily dosage of 1 g or less. This on rare occasions may be associated with hemolytic anemia, which could lead to potentially fatal complications. One cannot predict which patients with a positive direct Coombs test may develop hemolytic anemia. Prior existence or development of a positive direct Coombs test is not in itself a contraindication to use of methyldopa. If a positive Coombs test develops during methyldopa therapy, determine whether hemolytic anemia exists and whether the positive Coombs test may be a problem. For example, in addition to a positive direct Coombs test there is less often a positive indirect Coombs test which may interfere with cross matching of blood.

At the start of methyldopa therapy, it is desirable to do a blood count (hematocrit, hemoglobin, or red cell count) for a baseline or to establish whether there is anemia. Periodic blood counts should be done during therapy to detect hemolytic anemia. It may be useful to do a direct Coombs test before therapy and at 6 and 12 months after the start of therapy. If Coombs-positive hemolytic anemia occurs, the cause may be methyldopa and the drug should be discontinued. Usually the anemia remits promptly. If not, corticosteroids may be given and other causes of anemia should be considered. If the hemolytic anemia is related to methyldopa, the drug should not be reinstituted. When methyldopa causes Coombs positivity alone or with hemolytic anemia, the red cell is usually coated with gamma globulin of the IgG (gamma G) class only. The positive Coombs test may not revert to normal until weeks to months after methyldopa is stopped.

Should the need for transfusion arise in a patient receiving methyldopa, both a direct and an indirect Coombs test should be performed on his blood. In the absence of hemolytic anemia, usually only the direct Coombs test will be positive. A positive direct Coombs test alone will not interfere with typing or cross matching. If the indirect Coombs test is also positive, problems may arise in the major cross match and the assistance of a hematologist or transfusion expert will be needed.

Fever has occurred within first 3 weeks of therapy, occasionally with eosinophilia or abnormalities in liver function tests, such as serum alkaline phosphatase, serum transaminases (SGOT, SGPT), bilirubin, cephalin cholesterol flocculation, prothrombin time, and bromsulphalein retention. Jaundice, with or without fever, may occur, with onset usually in the first 2 to 3 months of therapy. In some patients the findings are consistent with those of cholestasis. Rarely fatal hepatic necrosis has been reported. These hepatic changes may represent hypersensitivity reactions; periodic determination of hepatic function should be done particularly during the first 6 to 12 weeks of therapy or whenever an unexplained fever occurs. If fever and abnormalities in liver function tests or jaundice appear, stop therapy with methyldopa. If caused by methyldopa, the temperature and abnormalities in liver function characteristically have reverted to normal when the drug was discontinued. Methyldopa should not be reinstituted in such patients.

Rarely, a reversible reduction of the white blood cell count with primary effect on granulocytes has been seen. Reversible thrombocytopenia has occurred rarely. When used with other antihypertensive drugs, potentiation of antihypertensive effect may occur. Patients should be followed carefully to detect side reactions or unusual manifestations of drug idiosyncrasy.

Pregnancy and Nursing: Use of any drug in women who are or may become pregnant or intend to nurse requires that anticipated benefits be weighed against possible risks; possibility of fetal injury or injury to a nursing infant cannot be excluded. Methyldopa crosses the placental barrier, appears in cord blood, and appears in breast milk.

Precautions: Should be used with caution in patients with history of previous liver disease or dysfunction (see Warnings). May interfere with measurement of: urinary uric acid by the phosphotungstate method, serum creatinine by the alkaline picrate method, and SGOT by colorimetric methods. Since methyldopa causes fluorescence in urine samples at the same wavelengths as catecholamines, falsely high levels of urinary catecholamines may be reported. This will interfere with the diagnosis of pheochromocytoma. It is important to recognize this phenomenon before a patient with a possible pheochromocytoma is subjected to surgery. Methyldopa is not recommended for patients with pheochromocytoma. Urine exposed to air after voiding may darken because of breakdown of methyldopa or its metabolites.

Stop drug if involuntary choreoathetotic movements occur in patients with severe bilateral cerebrovascular disease. Patients may require reduced doses of anesthetics; hypotension occurring during anesthesia usually can be controlled with vasopressors. Hypertension has recurred after dialysis in patients on methyldopa because the drug is removed by this procedure.

Adverse Reactions: *Central nervous system:* Sedation, headache, asthenia or weakness, usually early and transient; dizziness, lightheadedness, symptoms of cerebrovascular insufficiency, paresthesias, parkinsonism, Bell's palsy, decreased mental acuity, involuntary choreoathetotic movements; psychic disturbances, including nightmares and reversible mild psychoses or depression.

Cardiovascular: Bradycardia, aggravation of angina pectoris. Orthostatic hypotension (decrease daily dosage). Edema (and weight gain) usually relieved by use of a diuretic. (Discontinue methyldopa if edema progresses or signs of heart failure appear.)

Gastrointestinal: Nausea, vomiting, distention, constipation, flatus, diarrhea, mild dryness of mouth, sore or "black" tongue, pancreatitis, sialadenitis.

Hepatic: Abnormal liver function tests, jaundice, liver disorders.

Hematologic: Positive Coombs test, hemolytic anemia. Leukopenia, granulocytopenia, thrombocytopenia. Positive tests for antinuclear antibody, LE cells, and rheumatoid factor.

Allergic: Drug-related fever, lupus-like syndrome, myocarditis.

Other: Nasal stuffiness, rise in BUN, breast enlargement, gynecomastia, lactation, impotence, decreased libido, dermatologic reactions including eczema and lichenoid eruptions, mild arthralgia, myalgia.

Note: Initial adult dosage should be limited to 500 mg daily when given with antihypertensives other than thiazides. Tolerance may occur, usually between second and third months of therapy; increased dosage or adding a diuretic frequently restores effective control. Patients with impaired renal function may respond to smaller doses. Syncope in older patients may be related to increased sensitivity and advanced arteriosclerotic vascular disease; this may be avoided by lower doses.

How Supplied: Tablets, containing 125 mg methyldopa each, in bottles of 100; Tablets, containing 250 mg methyldopa each, in single-unit packages of 100 and bottles of 100 and 1000; Tablets, containing 500 mg methyldopa each, in single-unit packages of 100 and bottles of 100 and 500.

For more detailed information, consult your MSD representative or see full prescribing information.
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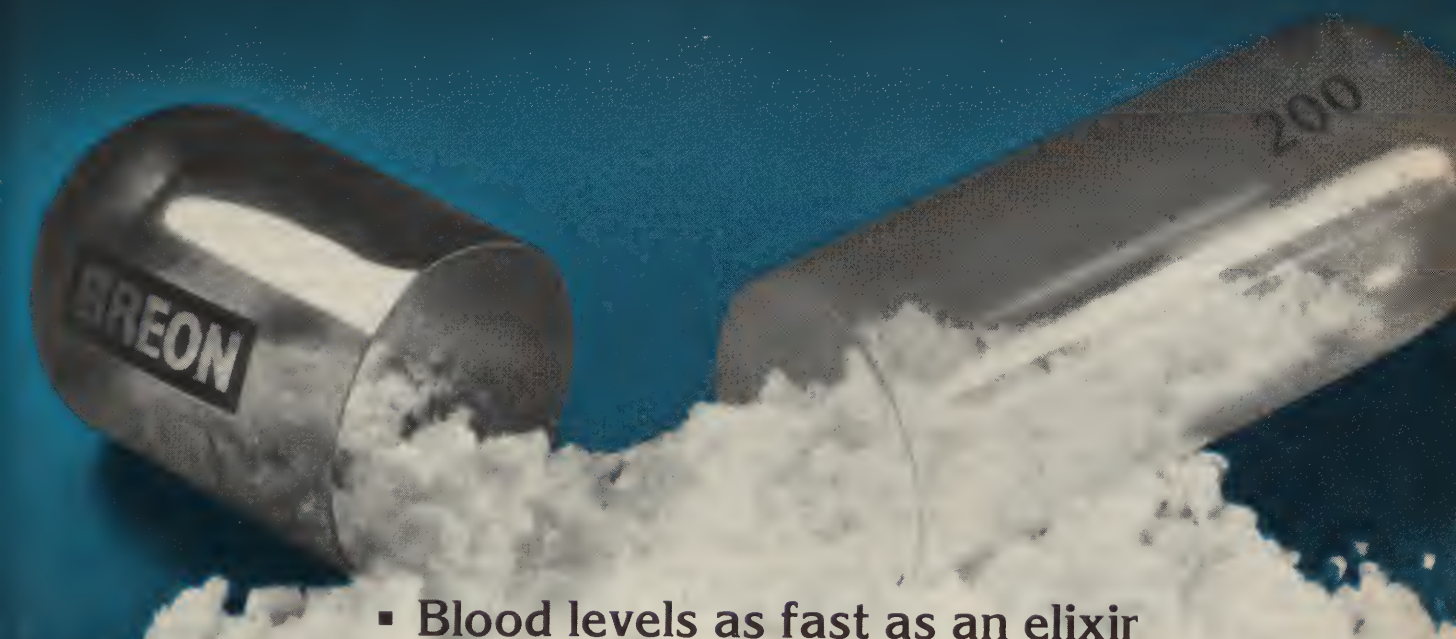
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DESCRIPTION:
Each green and white hard gelatin capsule contains theophylline USP anhydrous, 200 mg., in a micro-pulverized form. Each brown and white hard gelatin capsule contains 100 mg. The elixir contains 80 mg. theophylline per 15 ml. in a 20% alcohol elixir (approximately 20 calories, 0.9 gm carbohydrate per tablespoonful).

ACTION: Theophylline is a methylxanthine which relaxes the smooth musculature of the bronchioles through its inhibition of the conversion of cyclic adenosine monophosphate to adenosine monophosphate by phosphodiesterase. It also has diuretic, cardiotonic, and CNS stimulant effects.

INDICATIONS: Bronkodyl is indicated for symptomatic relaxation of bronchiolar spasm in the chronic obstructive bronchopulmonary diseases; e.g., bronchial asthma, chronic bronchitis and pulmonary emphysema.

CONTRAINDICATIONS: Bronkodyl is contraindicated in persons known to have had serious idiosyncratic responses to theophylline, its salts, or the other methylxanthines, theobromine, or caffeine and may be contraindicated in peptic ulcer.

WARNINGS: All methylxanthines should be used with caution in children and in others who are currently taking bronchodilator products, especially in rectal dosage form, which may contain theophylline or related drugs.

USAGE IN PREGNANCY: Although theophylline has been used for many years, with no evidence of adverse fetal effect or teratogenicity, its safety in pregnancy has not been established. Therefore use of Bronkodyl during lactation or in women of childbearing potential requires that possible benefits of the drug be weighed against possible hazards to fetus or child.

PRECAUTIONS: Bronkodyl should be used with caution in patients with cardiac or circulatory disease.

ADVERSE REACTIONS: Gastrointestinal: Epigastric distress, nausea, vomiting. Cardiovascular: palpitations. CNS: Insomnia, restlessness, irritability, convulsion.

DOSAGE AND ADMINISTRATION: Adults: Usual dosage of Bronkodyl is 200 mg. every 6 hours (four doses in each 24 hours). This dosage may be adjusted to reflect individual clinical response as an indication of slow or rapid metabolism of the drug. If adverse reactions are encountered, each dose may be reduced, or the interval between doses may be lengthened, or both. If clinical response is not satisfactory, indicating possible rapid inactivation of the drug, dosage may be gradually increased to achieve the desired response. In some instances of either too slow or too rapid metabolism, plasma levels of theophylline should be determined and dosage adjusted accordingly to achieve levels above 10 mcg/ml, but not to exceed 20 mcg/ml.

Dosage in Children: Usual dosage should be based on administration of 10 mg per kg per 24 hours, divided in 4 doses per day, given every 6 hours. As this may not be possible with use of the capsules, Bronkodyl elixir may be used. Theophylline saliva levels (approximately 60% of simultaneous blood levels), may facilitate dosage adjustments, especially in children, to obtain appropriate response.

HOW SUPPLIED:
Bronkodyl 100 mg., brown and white capsules in 100's, Code #1831.
Bronkodyl 200 mg., green and white capsules in 100's, Code #1833.
Bronkodyl Elixir, 80 mg. per 15 ml, in pints, Code #1835.

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Treating sexual dysfunctions in women

JOYCE D. KALES, M.D. ENOS D. MARTIN, M.D. EVALYN M. STRICKLER, M.S.W.

Female sexual dysfunctions may present indirectly, in the form of functional complaints, or directly, with symptoms of sexual arousal dysfunction, orgasmic dysfunction, or vaginismus.

When the physician suspects or is told of sexual problems, he should attempt to identify the circumstances under which the dysfunction occurs and offer the patient a sequence of sexual tasks for treatment of the condition. In addition, he should learn to counsel the patient and her partner on issues of partner trust and positive communication of preferences.

Table I summarizes the causes, diagnosis, and treatment of common female sexual dysfunctions.

Sexual arousal dysfunction

The term "sexual arousal dysfunction" is preferred to the older term "frigidity," which suggests that the woman may be rejecting, hostile, and cold toward men. The latter term is often inaccurate and may serve to confuse the problem.

In understanding sexual arousal dysfunction in women, it is important to remember that the physiologic sexual response in both men and women is biphasic. Genital vasocongestion producing penile erection in the male and vaginal lubrication and swelling in the female is the first phase. The second phase is marked by involuntary contractions of the genital musculature, or orgasm.

The condition of sexual arousal dysfunction exists when psychic and physical erotic stimulation fail to result in the woman's arousal and accompanying vaginal lubrication and engorgement of the genitalia. It is comparable to impotence or erectile dysfunction in the male. The severity of the condition varies from a marked revulsion toward sexual activity in some women to a lack of interest in coitus in others. In some cases of nonarousal, intercourse is accepted willingly because of the attention, closeness and warmth it brings, even though there is an inability to experience truly erotic sensations.

Diagnosis—The physician should distinguish between primary sexual arousal dysfunction, in which the woman has never experienced erotic pleasure in any situation, and secondary arousal dysfunction, in which the woman has responded in the past to sexual activities with some degree of erotic pleasure but currently cannot respond.

While male impotence may be organically caused in 10 percent of all cases, female sexual dysfunction is nearly always psychological in origin. There are few physical illnesses that specifically affect female sexual arousal to the same extent as those affecting the male. Diabetes mellitus, for example, does not typically affect the female sexual response unless the condition is advanced. Rarely, endocrine disorders, such as pituitary dysfunction, or neurological diseases, such as multiple sclerosis, may result in impaired female sexual responsivity.

Female sexual arousal also may be inhibited by the use of alcohol, sedatives, hypnotics, narcotics, or autonomic agents. The effects of oral contraceptive medications on libido vary. Women often experience an increase in libido when first taking the pill because of the lessened fear of pregnancy and an increased ability to be more spontaneous. As oral contraceptive medications are continued, however, they may reduce libido through an anti-androgenic effect.

The psychological causes of sexual arousal dysfunction, by far the most common, may be a result of culturally determined attitudes (such as "nice girls don't enjoy sex"), misinformation (such as "women do not have as much sexual interest or capability as men"), or concern about the possibility of pregnancy.

Inadequate foreplay or premature ejaculation may result in the termination of lovemaking before the female has become aroused; if arousal occurs, persistent failure to climax may create frustration which in turn may result in sexual arousal dysfunction. This may lead to aversion, resentment, or disinterest by the woman.

Arousal may also be impaired by depression, anxiety about performance, difficulty in communicating desire for various types of sexual stimulation, chronic anger, and fatigue. Deeper conflicts stemming from guilt over childhood sexual prohibitions, incest, or rape may occasionally affect arousal and may require intensive psychotherapy in addition to specific behavioral assignments.

Treatment—The sexually unresponsive woman needs assurance that sexual arousal is a natural and wholesome physiologic function. It may be helpful for her to know that vaginal lubrication and clitoral engorgement occur cyclically during sleep, just as erection in males occurs naturally during periods of REM, or dreaming, sleep. The woman must also understand that it is her prerogative and responsibility to permit her own responses to unfold when she is properly stimulated, and not the male partner's responsibility to "make" her feel aroused. The woman may have learned to psychically inhibit her natural responses and should learn to disinhibit them.

The physician's understanding can be an important support in giving the woman "permission" to affirm her own sexuality and overcome her crippling inhibitions. For some women, an important preliminary step in becoming sexually responsive is to become familiar with and explore their external genital anatomy through self-examination with a mirror.

The general methods involved in treating sexual arousal dysfunction include sensate focus or "pleasuring" exercises, exercises for the female pel-

Dr. Kales is director of the division of community and social psychiatry and of the sex education program and sexual dysfunctions clinic of the department of psychiatry of The Pennsylvania State University College of Medicine in Hershey. Dr. Martin and Ms. Strickler are associates in the department.

vic musculature, self-stimulation, and the "stop-start" form of intercourse with nondemand vaginal containment. As these various tasks are prescribed, intercourse should not be attempted for several weeks.

The sensate focus exercises require that the woman and her partner schedule several uninterrupted periods a week in which they take turns caressing each other in a relaxed way with no demand for sexual performance. The couple should communicate the ways in which they like to be caressed. If there is any discomfort, each partner should mention the discomfort and suggest a way to decrease it, making positive suggestions rather than critical remarks. For example, the patient should not say, "You are really awkward and clumsy," but rather, "Please caress me more gently."

At first the genital area is avoided, but after the exercises have been completed comfortably for several sessions, genital caresses should be included. The couple should concentrate on eliminating any discomfort with the exercises rather than trying to produce sexual arousal.

Exercises to enable the female patient to become more aware of and strengthen the pelvic and pubococcygeus muscles (Kegel exercises) may be helpful. The pubococcygeus muscle is the muscle that interrupts the flow of urine. By contracting this muscle ten or fifteen times, three times a day for two or three months, perivaginal muscle tone will improve. This results in pleasurable feelings in the genital area and, eventually, heightened arousal and orgasm during intercourse.

Self-stimulation, whether manual or with the use of a vibrator and accompanying erotic literature and fantasy, is often recommended. With this method there is no demand on the woman to perform and she is free to recognize erotic sensations and learn the techniques that arouse her. She can then communicate to her partner what pleases her the most. Often the woman experiences orgasm during self-stimulation; if she does not, no effort should be made to achieve orgasm at this point, for it eventually will occur naturally.

When the preceding exercises can be performed comfortably, the couple is advised to begin nondemand vaginal containment after preliminary pleasuring with genital stimulation. The woman, assuming the superior position, inserts her partner's penis into her vagina and holds it there with no thrusting for about 15 seconds. If discomfort or pain is experienced due to insufficient lubrication, a lubricating jelly may be used. This nondemand vaginal containment exercise should be repeated three or four times within a session, after which either partner or both may reach orgasm by manual or oral stimulation.

After one or two such sessions of comfortable vaginal containment without thrusting, the couple may add slow thrusting to the exercise but should avoid rapidly increasing the amount and rate of motion. By being in the superior position, the female can control the thrusting at a rate she finds comfortable. Again, orgasm may be achieved by manual or oral stimulation or intravaginally when the individuals feel ready.

Orgasmic dysfunction

The female orgasm has been a source of confusion because of the subjective and diffuse nature of the female sexual experience. Masters and Johnson have corrected the notion that there are two kinds of orgasm, clitoral and vaginal: the female orgasm is neurophysiologically identical whether produced by self-stimulation, coitus, or manual or oral stimulation, although it may vary in intensity. Another source of confusion is the capacity of some females for multiple orgasm. Unlike the male, the female has no refractory period: she may be capable of successive orgasms if stimulation continues from plateau levels of sexual arousal.

Diagnosis—In orgasmic dysfunction, the woman experiences sexual arousal, vaginal lubrication, and vasocongestion. There is, however, an absolute or relative inhibition of the orgasmic reflex. The spectrum of orgasmic dysfunction includes women who have never experienced orgasm (primary), women who have experienced orgasm in the past but are unable to do so currently (secondary), and women who are able to experience orgasm only in certain situations (situational). Diagnosis of the disorder should include a determination of the type of dysfunction involved.

A common cause of orgasmic dysfunction that is often overlooked is that the woman has simply not been sufficiently stimulated by her partner. As with sexual arousal dysfunction, medical conditions such as diabetes mellitus, certain neurologic and endocrine disorders, and the effects of alcohol and other drugs, are seldom the cause of orgasmic dysfunction.

Orgasmic dysfunction frequently is due to psychological factors, which may result from ill-formed attitudes, misinformation, or a fear of pregnancy. During the orgasmic reflex, volun-

Table I - Female Sexual Dysfunctions

	Causes	Diagnosis	Treatment
Arousal dysfunction	Usually psychological; medical causes infrequent	Distinguish between primary and secondary sexual arousal dysfunction	Self examination Sensate focus exercises Pubococcygeus muscle exercises Self stimulation Start-stop intercourse
Orgasmic dysfunction	Often due to inadequate stimulation or psychological causes; medical causes infrequent	Distinguish primary, secondary, or situational orgasmic dysfunction	Self stimulation Sensate focus Transfer orgasm to coitus Start-stop intercourse
Vaginismus	Often due to extreme fear of penetration and trauma	Rule out physical abnormalities	Gradual vaginal dilation using fingers or dilators Relaxation exercises and pleasant imagery Penile containment

tary control is relinquished over the body and emotions. A woman who is fearful and unwilling to give up conscious control of her body may experience difficulty some or all of the time with the orgasmic phase of sexual response, even though she has no difficulty becoming aroused.

Some non-orgasmic women may experience anxiety in reaction to their physiologic response to higher levels of sexual arousal, such as increased breathing, heart rate, and muscular tension. Some women may become tense because they try to "produce" an orgasm rather than allowing the experience to occur naturally, thus inhibiting the response. Other women may simulate an orgasm to please their partners and fulfill their expectations, even though the women themselves have not reached an orgasmic level of excitement.

Treatment—Effective treatment for orgasmic dysfunction begins with the female's recognition of the conditions that allow her to experience orgasm. For the primarily non-orgasmic woman, several periods of self-stimulation free from the pressure to satisfy and please the partner, along with the use of erotic literature, should be suggested. This may be necessary to identify the heightened level of arousal needed to achieve orgasm and to avoid the concerns about self-performance that may exist during coitus. If the self-stimulation is not sufficiently intense to produce orgasm, the use of a vibrator may be indicated.

Once the woman with primary orgasmic dysfunction is able to achieve orgasm through self-stimulation within a reasonable period of time, the next step is to transfer the orgasm to the heterosexual situation. The treatment used to accomplish this is the same as that for women who may experience orgasm with clitoral stimulation, but are situationally non-orgasmic with intercourse.

Various suggestions can be offered to the woman who wishes to become orgasmic with coitus. The sensate focus exercises previously described, practiced by the couple first without and then with genital caresses, are useful for building the woman's sexual tensions. When she feels aroused, the "start and stop" method of coitus is used.

Brief periods of penile insertion with nondemand vaginal containment are followed by slow teasing, thrusting, and then withdrawal. During the withdrawal periods, foreplay continues using clitoral stimulation to maintain and build the woman's level of arousal. The sequence of withdrawal, foreplay, vaginal containment, and slow thrusting is repeated until the woman feels orgasm is impending, at which point she begins to thrust more vigorously. When orgasm does not occur with penile stimulation alone, a coupling technique of combining penile thrusting with manual stimulation may be used.

Partner support is necessary for the woman to temporarily avoid preoccupation with her partner's gratification and to learn to accept her own erotic sensations. The woman should also be advised to practice the pubococcygeus muscle exercises.

With secondary and other types of situational orgasmic dysfunction, the physician should first identify the conditions which may have precipitated the dysfunction. Often the physician can proceed with the sequence of sexual tasks just described for the non-orgasmic woman. In other cases, specific psychological or marital conflicts may have to be resolved before these sexual tasks are prescribed.

The general approach to the treatment of orgasmic dysfunction requires that the partners learn to share their sexual feelings and preferences. The sexual tasks prescribed may serve to highlight problems with trust, poor communication, previously existing hostility, and fear of rejection in the relationship. These factors often must be discussed to allow the couple to proceed with the sexual exercises. Deeper anxieties about control, dominance and submission, or long-standing conflicts stemming from childhood experiences may require intensive psychotherapy for resolution.

Vaginismus

Vaginismus is a condition of involuntary spasm of the pelvic muscles surrounding the vaginal orifice and of the lower one third of the vagina, making penile penetration difficult or impossible.

Diagnosis—Abnormalities such as vaginal infection, imperforate or rigid hymen, or abnormalities of deeper pelvic structures must be ruled out by physical examination. Usually the condition is caused by a fear of penetration and trauma during coitus which may be of phobic proportions. Vaginismus may be the cause of unconsummated marriages even when there is a loving relationship and the woman is sexually responsive with forms of lovemaking other than coitus.

Treatment—With proper instructions from the physician, the treatment of vaginismus is carried out at home by the patient and her partner. This treatment involves gradual dilation of the vaginal orifice provided that any physical factor has been treated beforehand. The well-lubricated little finger followed by the index finger, two fingers, and then the partner's finger, etc., may be used. Graduated, lubricated dilators of increasing size may also be recommended.

While dilation is being accomplished, it is important to also desensitize the patient to the fear of penetration. General relaxation exercises are helpful during this phase of therapy. The patient should be instructed to relax her body musculature and visualize a pleasant and relaxing scene while the dilator is in place. When this is achieved comfortably, she gradually begins to picture the approach of her partner, fantasizes his approach with an erection, and then fantasizes penetration.

Intercourse should not be attempted until dilation and desensitization have been well tolerated. Initially, the penis should be inserted and simply contained for a brief period of time. When this is comfortably tolerated, slow and gentle thrusting is permitted. Coitus proceeding to orgasm is deferred until complete comfort is attained with penile containment.

With the understanding and support of a well-informed physician, most women with sexual dysfunction can satisfactorily utilize the sexual tasks described. However, deeper intrapsychic causes may be present when female sexual dysfunction does not improve with these treatment procedures. In these cases, referral for individual or marital psychotherapy should be considered. □

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Special tax problems face incorporated physicians

LEIF C. BECK, LL.B., C.P.B.C.
VASILIOS J. KALOGREDIS, J.D.
Bala Cynwyd

Practicing medicine in a professional corporation has become so routine that many physicians are ignoring its risks and demands. We are struck by the number of accountants and attorneys who are unconcerned or unaware of the problems. As a result, various "horror stories" of mishandled corporations and very unhappy physician-members circulate.

Our article is addressed to some of the concerns and opportunities we consider important as we head into 1978.

Reasonable compensation

The much-discussed issue of reasonableness of compensation continues to exist. Corporations throughout the US have been challenged by IRS agents about whether amounts paid the doctors are totally deductible—whether they are "reasonable" as salaries to those who also own their corporation's stock.

In many cases, the IRS has ceased its attack upon the showing of some fairly moderate circumstances. We urge fairly simple protective steps to reduce these risks.

The first step is to preplan the physician-shareholders' salaries for monthly (or even biweekly or weekly) payments. If the fiscal planning is successful, there should be no year-end bonuses.

A pattern of such bonuses to shareholders has led several courts to decide they were nondeductible dividends rather than "reasonable compensation." Receipt of equal monthly salary checks provides good tax protection and permits more efficient personal budgeting.

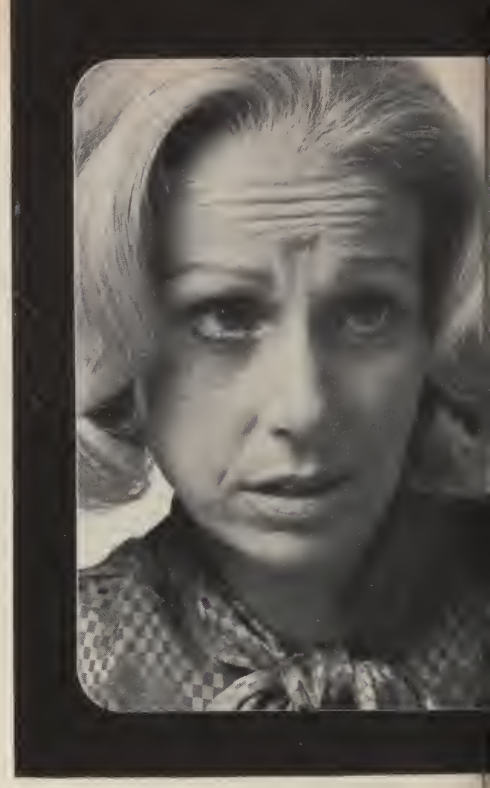
Gross income may rise faster than can be preplanned, leaving at year's end an almost unavoidable extra amount for the doctors. Recognizing this possibility, we strongly prefer to install an "incentive compensation" clause in employment contracts.

The clause recognizes that higher gross income generally arises only from increased physician services (although fee increases could be another reason), for which the physicians deserve more pay. While not guaranteed to avoid IRS attack,* the incentive compensation arrangement is a good effort to show special compensatory reasons for paying year-end bonuses.

A second protective step is to leave some of the corporation's net income behind as corporate "profit." Such profit is subject to federal and state taxation, but it is a small price to pay for good tax results upon IRS audit. A number of courts have pointed to a corporation's continuing lack of profits (especially coupled with year-end "drain out" bonuses to the shareholders) as proof that the salaries paid to the owners were unreasonably high.

The third step is to establish a record of paying cash dividends regu-

** Two Tax Court decisions have considered incentive compensation payments to corporate owners to be "dividends," or disguised efforts to pay out corporate earnings. The facts in these cases can be differentiated from many medical practice situations.*



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INDICATIONS: For the prophylaxis and long-term treatment of patients with frequent or recurrent anginal pain and reduced exercise tolerance associated with angina pectoris, rather than for the treatment of the acute attack of angina pectoris, since its onset is somewhat slower than that of nitroglycerin.

PRECAUTIONS: As with other effective nitrites, some fall in blood pressure may occur with large doses.

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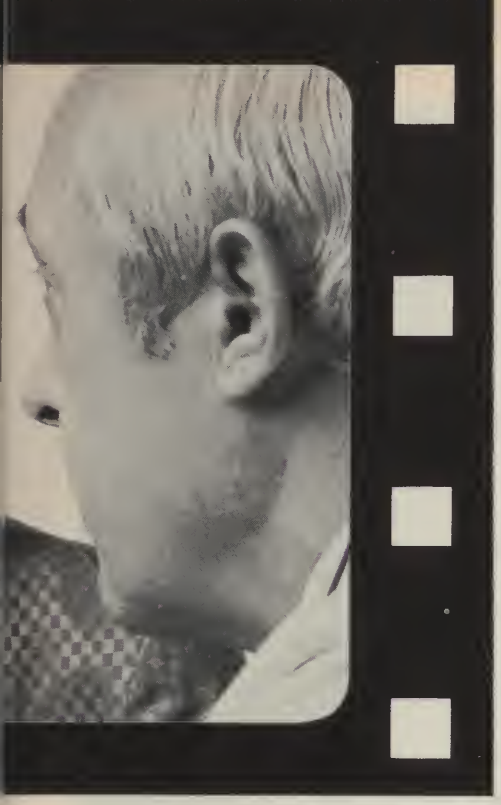
Mild gastrointestinal disturbances occur occasionally with larger doses and may be controlled by reducing the dose temporarily.

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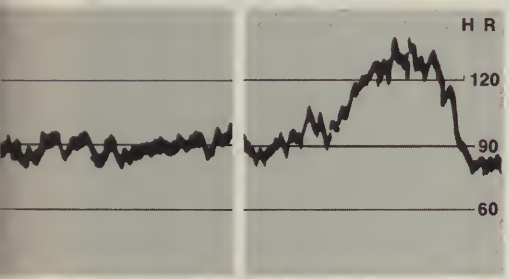
"**Our sex life is nil...**" A problem of the first magnitude to many post infarct patients and their mates...patients are often reluctant to broach the subject; physicians may frequently overlook its implications. This new 16mm film combines candid patient interviews with discussions by Drs. Herman Hellerstein, Thomas Hackett, Albert Kattus, Richard Stein, Carroll Witten and Lenore Zohman. Film and related monograph comprise 2 AAFP credit hours. To arrange viewing, write Burroughs Wellcome Co., Educational Services Department, Research Triangle Park, N.C. 27709 or contact your B.W. Co.® representative.

Sex and the heart patient:

A film every doctor should see.

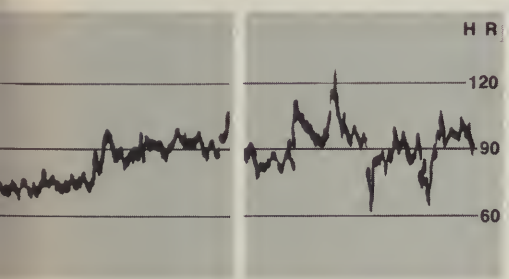
The energy cost of sex to the heart is relatively modest.
Over 80% of post-coronary patients can ultimately resume sexual activity without serious risk. Hellerstein and Freedman demonstrate that mean maximal heart rate during orgasm with spouse (as opposed to extra-marital sex) in 14 post-infarct patients is lower than that during usual occupational activity.

Representations below of actual EKG readings of an attorney, post MI, illustrate the point:



A. Working in office (about 90 beats/min)

B. Confrontation in judge's chamber (about 125 beats/min)



C. Pre-orgasm sex activity (about 90 beats/min)

D. Peaks at orgasm (120 beats/min)



Fear of pain greatest deterrent to post MI sex
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larly to the physician-shareholders. Several courts have combined the lack of dividends with annual last-minute bonus payments to prove that some bonus amounts really were dividends, or returns to the shareholders as *owners* (not employes) of their practices.

We recommend annual dividends ranging from $100 to $1,000 (and more in some special cases) to keep the reasonable compensation issue fairly remote.

Business expenses

Directors' resolutions or employment contracts, and in some cases both, will typically state which professional expenses are to be paid by the corporation. These documents may also specify which other expense items must be paid personally by the physician. Clarification of business expense arrangements is particularly important in group practice, even if only two doctors are involved, to prevent misunderstanding among the members.

Despite the written provisions, however, it is not unusual for doctors unwittingly to pay corporation expenses out of their personal funds, or vice versa. Tax agents are correct in disallowing the attempted deduction of mistaken payments on the basis that they are the other party's expenses. Only the taxpayer who actually must pay a business expense is entitled to deduct it.

Recognition of the problem makes avoidance easy. Careful planning will increase each doctor's awareness of which "pocket" (corporate or personal) should pay each expense. If the doctors wish to change the payment arrangements, perhaps having more expenses paid by the corporation, the underlying contracts or board resolutions can be amended easily.

Preferential dividends

The typical approach to tax planning has been to claim any arguably business-related expense as a tax deduction in the hope that the tax return will not be reviewed or that the IRS agent will accept the claim. When a deduction is disallowed, nothing is lost from a tax standpoint—except an acceptable rate of interest on the extra tax.

Professional corporations commonly use this system, hoping that the marginal business expenses will be overlooked or accepted on the corporate return while the doctor's return is "clean" of those items. Examples include extensive automobile expenses, payment of country club dues, travel to meetings which combine with personal vacations, entertainment expenditures, and the like.

The IRS recently has taken a position on unacceptable business expenses which makes the old approach of simply "running them through the corporation" questionable. In disallowing the expenses as deductions on the corporate tax returns, the IRS has correspondingly taxed them to the physician-shareholders as "preferential dividends."

The result of this approach is greater tax liability than if the expense had not been deducted in the first place. Assume, for example, that a $1,000 travel item were so disallowed. There would first be a 20 percent income tax (plus any state corporate income tax) imposed on the corporation, while the entire $1,000 would also be added to the doctor's tax return as a dividend. In the case of the high-income doctor, dividends will be taxed at even more than the 50 percent maximum tax on his earnings from practice. The total tax liability would thus be at least $700.

Had the physician simply not claimed the $1,000 expense, the tax liability would have been only $500. The situation thus dictates increased conservatism in claiming "business-related" expenses. If the doctor and his accountant honestly doubt the deductibility of an expense in case of a thorough IRS review, money might be saved by not running it through the corporation at all.

Hedge clauses

Many, perhaps most, incorporated physicians' employment agreements or bylaws include some form of "hedge clause" in the expectation that it will offer insulation in case of tax audit.

The authors are the principal consultants of Management Consulting for Professionals, Inc., Bala Cynwyd.

Such a clause essentially provides that if the IRS should determine any part of the doctor's compensation, fringe benefits, or expense arrangements to be nondeductible as "unreasonable compensation," the doctor will repay the amount to his corporation. Since his repayment is deductible on his personal tax return, the clause is intended to discourage IRS attack in the first place.

We have always been opposed to such hedge clauses, and recent Tax Court decisions strengthen that belief. Our basic reasons have been practical, for the doctor first must be willing and able to repay the "unreasonable" amounts out of available cash if the situation should arise. Furthermore, once he has done so, the corporation will have the income (subject to tax) and the likely need to pay it back out to or for the doctor. The hedge clause, then, simply restores the original tax planning problem—it does not solve it.

The Tax Court recently considered several cases in which "unreasonable compensation" was asserted by the IRS despite the existence of hedge clauses. In addition to showing that the clauses did not prevent the attack, the Court's language is particularly damning. It concluded that the hedge clauses helped prove the parties' knowledge that some of their pay might be unreasonable. In effect, the clauses worked against the taxpayers rather than for them.

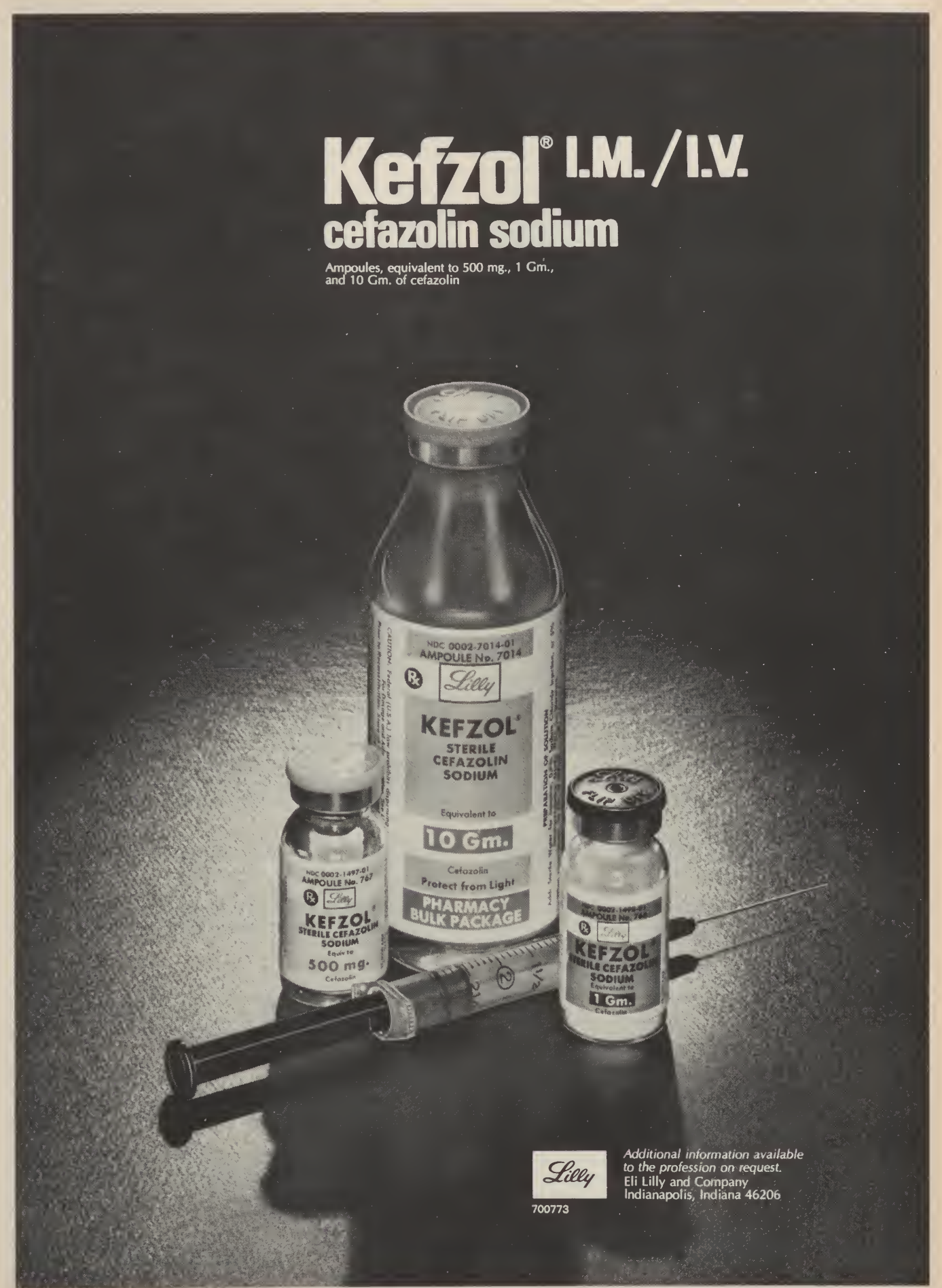
We see no reason for including such reimbursement provisions in well-managed professional corporations. The "unreasonable compensation" problem can be minimized by careful and conservative planning. In that light, a "hedge clause" may cause far more trouble than it will prevent.

Other problems are inherent in poorly managed professional corporations. Many of them are revealed only when a shareholder dies, retires, or leaves the practice. It is this instance that provides the real test of whether the corporate documents will truly perform as desired.

Most of the items described in this article are so simple to handle that ignoring them should be inexcusable. Yet the number of professional corporations that leave themselves open as "sitting ducks" for IRS audits indicates this discussion will be useful.□

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Dr. Blady sounds call for united action on goals

Members of the House of Delegates, Board of Trustees, Officers of the Society and guests, medicine has been my whole life. And while, through the years, I have seen our profession go through some very troubled times, I have never lost my faith in the integrity and devotion of doctors or my pride in the colleagues with whom I've served.

The profession is faced today with the problem of a national cancer. I am speaking of the proliferation of governmental interference into the practice of medicine. The encroachment of government into the practice of medicine has occurred at every level. We have seen it at the federal level with the vagaries of the medicare and medicaid laws, we have seen it at the federal level with the proposed cap on hospital revenues, we have seen it in the allegations of the FTC against the AMA and various specialty societies . . . at the state level, we have seen it in the aggrandizing schemes of the Health Department and its attempt to regulate every facet of medical practice.

Sometimes the government meets itself coming around the bend, as in the case of the FTC on the one hand blocking relative value scales as a form of price fixing, while at the same time planners in the Department of HEW talk about the use of relative value scales in setting up national fee schedules under socialized medicine.

At the state level, we see the Department of Health take a reasonably straightforward law like the 1972 Clinical Laboratory Act and, through regulatory fiat, turn it into a totally different law aimed at regulating office laboratories of physicians. Lacking sufficient numbers of personnel to guarantee quality of hospital and commercial laboratories, the department then holds itself out as protector of the public over 10,000 office laboratories.

Just over the past year or so in Pennsylvania alone, the litany of state agencies which have attempted to carve out a piece of the medical turf is startling:

1. Insertion of chiropractors into the black lung program. This intervention was engineered by the Governor, who used the power of the budget to attempt to bring his chiropractic friends into the treatment of black lung cases. Your Society, through vigorous action both in the public press and before the Governor's Black Lung Advisory Committee, was able to stop this.

2. The Department of Transportation, in its zeal to reform the Motor Vehicle Code, included language which would have required reporting to PennDOT the medical records of most patients in your office files. Again, through vigorous intervention by the Society and intensive negotiations with the secretary of transportation, language was introduced in the General Assembly to repeal this requirement from the new code.

3. After many years of delay, the Commonwealth will soon adopt new rules and regulations for the operation and licensing of hospitals. This enterprise has required strong input from PMS to the secretary of health to bring about needed revisions in those proposed rules and regulations.

As a matter of fact, I can recall a meeting of the PMS Board of Trustees in which we had to tell Secretary Bachman face-to-face how important it was to begin a committee dialogue with PMS on this subject. I am pleased to report that the secretary agreed; such a committee was formed and we have given the department valuable input.

4. On May 23, the state's new generic prescribing law went into effect. It was necessary for the Society to give strong lobbying input during the passage of that law so that our rights might be protected. It was additionally necessary for the Society, through its Commission on Therapeutics, to provide vigorous input to the Health Department in the administering of the law.

Early on, the Commission on Therapeutics successfully pointed out to the secretary of health deficiencies in expertise in the department. Subsequently, Dr. Bachman appointed a technical advisory group on which the Society received significant representation.

These are just some recent examples of state government intrusion into the practice of medicine. It requires a strong, alert Society to parry these thrusts and to protect the interests of its members.

It has become clear to me over the past two years that the issues at the federal and state levels are sufficiently diverse to require vigorous action by both the AMA and PMS.

PMS, except when asked to help by the AMA, focuses almost exclusively on the activities of the legislators and bureaucrats in Harrisburg. Meanwhile, the AMA in Chicago and Washington is looking out for our interests at the national level. To me membership in both the AMA and our state and county organizations is absolutely vital. I hope that all of us read the *American Medical Newsletter*, which epitomizes the activities of the AMA at the HEW, congressional, senatorial and presidential levels of counteractions and recommendations. Who dares to say that the AMA is inactive and unresponsive to direction from its membership?

If you hear colleagues criticize the AMA and feel alienated from its policies, it behooves you to inform them of the AMA's constant surveillance and vigilance. They simply fail to understand the tremendous job of representation the AMA does for us every day, particularly through its Washington office.

I shudder to think how much worse legislation and regulations from Washington would be if the AMA experts were not there to provide information and reaction to the Washington legislators and bureaucrats.

Here in Pennsylvania, the trend of government intervention into the practice of medicine is so pronounced that it leads me to make a recommendation.

In previous years, we tended to look upon the Council on Governmental Relations as the focal point regarding liaison with state government. But the intervention of the state bureaucracy into the practice of medicine has become so pronounced, the cancer has metastasized so widely, that this is no longer an adequate response.

I recommend that every Council of the State Society reexamine those activities within its purview which in any way relate to state government and assign to those activities that Council's highest priority.

I further recommend that the Councils come back to the House of Delegates next year and, as the first order of business in their annual reports, explain to us how they have gone about achieving the objective of better interface with state government.

We have become a nation of specialists because it is most difficult, or even impossible, for any one individual to encompass the breadth of medical knowledge today. Research has played an enormous part in new discoveries, new theories, and in developing new equipment and instrumentation. One of the outgrowths of this

specialization has been the development of our state and national specialty societies.

Filling an ever-growing scientific vacuum, these societies have become so strong that they have branched out beyond science and have begun to concern themselves with the socioeconomics of health care. By becoming involved in payment mechanisms to their own specialists they soon become entangled in government regulations and eventually in legislation itself.

As specialists, we must recognize that it will not be possible for each specialty to get everything that it desires. Each of us as a specialist has to sacrifice some of his objectives for the greater good of the profession. For me, the perquisites which come from the Doctor of Medicine degree mean much more and are worth far greater sacrifice than any that my specialty society could ever offer. We are first of all physicians.

I recommend that specialty societies with economic and legislative problems bring them to the Pennsylvania Medical Society to seek the support of the entire house of medicine for their cause prior to starting independent actions which may cause greater involvement than they foresaw and may produce difficulties in pursuing these activities.

With respect to the Pennsylvania General Assembly, the Pennsylvania Medical Society should be the primary spokesman for the profession in this state. Its opinion is the one that should be sought and offered to members of the Pennsylvania Legislature.

I believe that each of the specialties should discipline itself to work within that framework. If the Society for some reason is unable to be as responsive to a specialty's need as its doctors may wish, then all of the specialty's efforts should be directed toward the State Society to achieve the kind of support it needs.

Those efforts should not be diverted around the edge of the Society in independent action. Such splintering is counterproductive and dilutes the overall effectiveness of both organizations. It also confuses the legislators and offers them a favorite ploy—taking no action at all, since they view the house of medicine as divided.

At the same time, I am not satisfied with the amount of communication and liaison between the specialty societies and the Pennsylvania Medical Society. I understand that each of the specialties has a seat in the House of Delegates. I further understand that each of the specialties has a seat on the Interspecialty Committee. However, I am not satisfied that the flow of information to the specialties and from the specialties back to the Board of Trustees is adequate.

I recommend that the problem of specialty society representation and communication be referred to an appropriate reference committee for consideration at this meeting.

I need not tell you that today in this country there is a very serious problem concerning the cost of health care. Many of us in this room remember the great battles fought to forge Blue Cross and Blue Shield.

In solving yesterday's problem of paying the hospital bill and physician's bill, I fear we may have sown the seeds of today's problem of soaring health costs. Savings incentives and risk sharing have largely been excluded from the blue plans. As a result, the escalating costs of hospital and medical care go on spinning out of control.

Much has been written, discussed, and critically analyzed about health care costs without arriving at solutions that please all segments of society—the consumer, the medical profession, the hospital associations, the profit and nonprofit insurance carriers, the state and federal governments.

The federal approach has included PSRO, HMO, HSA, and the Health Manpower Act. So far, these government initiatives have succeeded only in spending federal dollars and creating confusion and much dissension, not in reducing health costs.

The medical profession must take serious cognizance of the overall cost of health care, for unless we do, our lack of leadership will surely come back to haunt us.

I believe that the health care cost issue is important enough that it should be assigned by the Board as a specific accountability to one of the councils or commissions of the Society. It should be responsible during the year for issuing information on ways of containing costs and should be required to make a report to this House of Delegates next year.

While the malpractice insurance crisis has not gone away, the



Gallup survey commissioned by the Society would indicate that it has backed down from its fever pitch of 1975. What we are seeing now, however, is the increasing practice of defensive medicine and the increasing cost of medical care as a result of rising malpractice premiums. The effects of the crisis are still very much with us and lead us to seek additional solutions to the problems.

We've been involved with malpractice for more than five years. We have battled to improve the climate but the legislature has not been very receptive to additional reforms. At the Insurance Department level, the Pennsylvania Medical Society has fought increases in premiums and has tried to arbitrate with the Argonaut Insurance Company in order to protect the insured physician's premium as well as his right to practice.

Those discussions over rate increases have been extremely costly, for they involved intervention in Insurance Department hearings and protracted, vigorous intervention of PMS attorneys and actuaries. We have spent over a half million dollars in this time on legal fees, actuarial fees, court suit costs, and associated expenses.

The contract with Argonaut, made in 1971, prevented the Society from affirmative and positive action. Instead we were limited to a defensive posture. Some members were being harassed unmercifully by court suits and nearly monthly increasing premiums. This created divisiveness which gave rise to opposition in the form of the Crisis Committee. This is regrettable but at the same time understandable.

Our Society has just reached a settlement with Argonaut which now permits it to launch PMSLIC, the captive company, which this House approved at the special meeting in 1976.

In order to confirm this settlement, our liability insurance company must raise sufficient policyholder surplus to meet the insurance commissioner's approval. This means that the membership must support and participate in PMSLIC to make it a success; otherwise, we revert back to the position before our present settlement was made.

As PMSLIC gathers statistical information on malpractice incidence in Pennsylvania, it should become possible to predict where our principle problems lie and to take corrective action.

The Society's Ad Hoc Committee under the leadership of Dr. Masland has been working on demonstration projects with the Hospital Association in risk management and binding arbitration. Both of these areas deserve our wholehearted support.

In order to better prepare us to meet the needs of the profession in the future, an ad hoc committee was appointed by the Chairman of the Board to study the structure of our Society. It has become clear to me through those deliberations that a number of changes are in order to clear the decks for some of the new priorities around the corner.

The Committee to Study Relations Between Medicine and Osteopathy has been on a standby basis since 1974 and recommends its abolition this year. I concur in that recommendation.

The Committee on Discipline has not been active and its responsibilities seem to parallel those of the District Censor and the Judicial Council. Therefore, the committee should be eliminated. At the same time the entire subject of discipline should be studied with an eye to improvement by the Society in the performance of this accountability.

The Committee on Medicine, Religion, and Bioethics was set up as a committee of the House of Delegates. Expansion of its deliberations into the field of genetics and other scientific considerations suggests that it should be incorporated as a commission of the Council on Education and Science.

The Standing Committee on Objectives should be discontinued since it duplicates the activities of the Ad Hoc Committee on Long Range Planning of the Board of Trustees.

The Committee on Relationships With Allied Professions is recommending its own dissolution and I would concur in that recommendation.

The reorganization of some of these special committees, standing committees, and commissions will better coordinate overall activities, avoid duplication, and improve both administration and costs.

We need to recognize the need for constant and vigorous supervision and support innovations that will keep our organization growing and responsive to the demands of a changing state and federal environment and demands by you, the membership.

We are now embarking on century three of the American experience and we must count ourselves lucky to be a part of this great drama. I choose to believe that we are not so much beset by problems as we are confronted with challenges and opportunities, for within every problem there lies the opportunity for a new solution.

I believe in organized medicine. The greater part of my professional life has been spent working for the profession in various specialty societies, the county society, and the State Society. I have done this because I firmly believe that only by working together can we achieve the goals we all seek.

Sometimes these goals demand great expense, but this we must recognize as the need to our salvation! I am confident that with a cooperative and understanding attitude by all of us in this coming year we can be a match for the many known and unknown challenges that the legislators and the bureaucrats are planning for us.

I thank you for giving me this opportunity to be your representative and I promise to do what I think will help all of us. □

Dr. Kelly reviews accomplishments, asks support

It seems incredible that a year has gone by since I stood before this group at the Bellevue in Philadelphia and delivered my inaugural address. Some of you may remember that speech. It was not calculated to lull you to sleep. Then, I was anxious to get started with the job of being president. I had a number of things I wanted to accomplish.

Twelve months later I am pleased to tell you that a great number of the projects which I outlined either have been accomplished or are well on the way toward completion. It has been quite a ride, this year of 1977, and the title I've given this speech is "Your Money's Worth" because, in my opinion, my friends, you have gotten your money's worth this year.

You'll recall I recommended a survey of this Society to find out what the members were thinking and to get us moving the way the doctors in this state want us to move.

I'm happy to report that survey has been completed. Questionnaires were mailed to 4,883 of the state's 21,000 physicians for a sample of 23 percent. The questionnaires were returned by 1,156 recipients for a response rate of 24 percent. A summary report prepared by Dr. Charles D. Pringle, Doctor of Business Administration at Penn State University, was presented to the PMS Board on April 22, 1977.

Generally speaking, members of the Pennsylvania Medical Society feel good about their State Society and the work that it is doing.

Despite this overall optimistic report, however, the survey did go into some areas in detail and reveal ways in which PMS could improve its performance and better satisfy its members.

You will recall that I was concerned about our governmental relations program and the need to give it more physician input. The survey showed that the respondent's perception of our lobbying program was directly related to the amount of information he received about it. Following up on the survey, the Council on Governmental Relations has instituted an executive committee which meets by telephone conference almost on a weekly basis. I feel this has improved the quantity and quality of physician input into the lobbying program.

In addition, this year we saw the institution of PLAN, Physicians' Legislative Action Network. As you recall, I asked each of your county and specialty societies and the Auxiliary to give me the name of a PLAN chairman, someone whom we could count on for help when the legislative going gets rough.

You responded beautifully to my request and the result is that we've been able to put together PLAN and throw it into action when the battle on the Hill called for citizen lobbyists as well as professional lobbyists.

The best example so far of PLAN in action has been on Senate Bill 586, the physician assistant bill. PLAN volunteers helped significantly in getting that through the Senate and over into the House.

Another part of that survey examined your attitude toward "member benefits." The information which has come back has been extremely helpful and has enabled the Council on Professional Relations and Services to revamp its membership recruiting programs.

We now believe that member benefits, such as group insurance programs, car leasing, personal loans, credit unions, etc., have their greatest appeal to nonmembers and young physicians. Therefore, the merchandising of these programs will be geared specifically to that target audience. The survey also told us the members want more all member polls.

We all know that the Chinese characterize each new year with the names of an animal. We are familiar with the year of the dragon and the year of the turtle. Well the PMS staff has little ways of characterizing the year of the PMS presidency. This year, a number of Teddy Roosevelt pictures and the word "bully" have

appeared in the Society offices, and that's all right with me because I planned this to be the year of the rough ride. It seems as though they disappeared from the desk tops when I was around.

You will remember that in my opening address I said we needed to take a close look at the structure of the Society and to do some streamlining. That close look has been going on this year. During these next three days you will be asked to act on a number of proposals to streamline Society organization. I urge you to act affirmatively. Some of these committees, such as the Committee on Objectives and the Committee on Discipline, have not produced results. This pruning operation is necessary because there are new areas demanding Society attention to which we must reallocate our scarce manpower. Two examples of this are hospital medical staff problems and the growing problems associated with long term care.

My heart may be in Pittsburgh with the Steelers, but part of me is from Missouri and just because we've always been cozy with Blue Shield doesn't mean that we have to continue to be that way. As a matter of fact, I raised this question in my speech last year. It turns out that I was about six months ahead of our attorneys, so, John, don't be too surprised if I submit a bill for legal advice.

This has been the year in which we've adopted a get-tough policy with Blue Shield. The Academy of Ophthalmology and Otolaryngology came to us and asked for help in their dispute with Blue Shield regarding its vision program. As you recall, that program was going to bring in optometrists and treat them as though they were medical doctors. The Society supported the Academy in its legal battle. We were able to secure ultimately agreement from Blue Shield that they would change the way their policies are written so as to make a proper distinction between the kind of service that an optometrist renders and the medical service that an ophthalmologist renders.

Since I am the president, I have the prerogative to digress, which I will do at this point and simply say that we also have honored a request from the Academy of Ophthalmology and Otolaryngology to assist them in their legal fight to gain recognition for their own eye care insurance program.

On our overall relationships with Blue Shield, PMS legal counsel concurs in my personal feeling that the time has come for the Pennsylvania Medical Society to sever its relationship with Pennsylvania Blue Shield. One of the things that will probably happen in this regard will be the termination of any further appointment by the Society of PMS Board members to the corporation of Blue Shield. I frankly welcome this arm's length relationship, because I think it will allow us to more candidly discuss our problems with Blue Shield. In short, we can take off the velvet gloves and really get down to cases.

At the outset I said you got your money's worth. Now let me give you some illustrations.

Again this year Argonaut was back requesting a sizeable rate increase—70 percent. PMS asked for and received intervenor status. The hearings on the 70 percent rate increase turned out to be the second longest insurance hearings in the history of the department. During those 16 days the Society, through its staff, attorneys, and actuaries, fought vigorously.

As you know, you came in on April 17 and determined not to support that 70 percent rate increase, but to go along with the change in territories and relativities. The bottom line of that marathon hearing was not a 70 percent rate increase but a 23.6 percent increase with the result being the savings of nearly six million dollars to PMS members.

In the succeeding months, PMS attorneys and actuaries intervened in an ISO filing and a JUA filing. While the ISO case is still to be settled, in the JUA filing we contributed to the ultimate opinion issued by the insurance commissioner. He denied the JUA the more than 40 percent increase requested and instead allowed 3 percent.

I have frequently heard it said that one must spend money to



make money, but at no time has this been so dramatically demonstrated to me as 1977. The cost of this "big stick" intervention in the rate setting process for malpractice insurance has been very expensive. The Society's legal costs alone have shot up more than 500 percent in the past two years.

Total legal costs in 1976 came to more than $240,000. During the first seven months of 1977, the Society spent more than $182,000 in legal costs and another $84,000 in actuarial fees. Those figures compare with normal legal fees in the $55–60,000 range.

But it has not just been in the rate setting operation where you've gotten your money's worth. 1977 was the year of litigation. Our battles with Argonaut have resulted in the $25 million dollar lawsuit by Argonaut against the Society.

That suit has vexed us all year and although it will be settled if we get the captive company operational, it will have cost us thousands of dollars in legal fees as we wind our way onward. It's cost us money but I personally feel our legal counsel has done a terrific job for us this year and I publicly thank them for it.

A number of members have objected to the mandatory insurance requirement of Act 111. This Society is responsive to the wishes of its members, so we have agreed to test the constitutionality of that requirement. Dr. Orlo McCoy, the trustee and councilor from the Twelfth District, is the physician who has carried the flag in this fight. That case is expected to be scheduled for argument next spring. To date, it has cost approximately $8,000.

The trial lawyers of this state have tried their best to knock down the arbitration section of Act 111. When these cases came to trial in Philadelphia, your State Society was an amicus curiae to the Commonwealth because we believe in the arbitration section of Act 111. This activity cost some $10,000.

Incidentally, we won the first round on this issue. The trial judge upheld the constitutionality of mandatory arbitration. The cases have now been appealed to the Pennsylvania Supreme Court.

Meanwhile, more than 40 mandatory prearbitration conciliation conferences have been held. Altogether about 35 cases have been closed *before* going to an arbitration panel. The total number of cases now reported for arbitration is about 350.

This was the year that saw the Society support physicians willing to countersue attorneys who have abused the legal system. Currently, the Society is supporting two such cases and reviewing others. The cost of this has been $25,000.

Ever since the new federal health planning law, PL 93-641, was enacted, controversy has arisen in the Philadelphia area as to the

boundaries for the HSA or HSAs. That fight continues to this day. The Philadelphia County Medical Society and its contiguous four county societies requested financial aid from PMS. We have pledged an opening $10,000 to that legal battle.

As I mentioned earlier, we are providing legal assistance to the Academy of Ophthalmology and Otolaryngology. The Quackery Committee is involved in a number of suits. The Society concluded without success this year in the Pennsylvania Supreme Court its litigation with the Department of Health over the Clinical Laboratory Act. Subsequently we have authorized the Council on Education and Science to negotiate with the Department of Health on the rules and regulations.

The Society did successfully conclude more than two years of litigation with the state regarding the unfair taxation of physicians' professional corporations. The Society won that suit and, henceforth, the state will not arbitrarily and capriciously use the corporate tax to attack the retirement assets of physicians' professional corporations. Over the long run, this legal investment by PMS represents a savings to the physicians of this Commonwealth of millions of dollars.

But one case that I have not mentioned yet which will cost us as much as $100,000 to defend next year is the antitrust action brought by the Pennsylvania Chiropractic Association. You know, if it weren't for the fact that our tail is being squeezed in so many other screen doors, this one might really be fun. We have been skirmishing with chiropractors for years.

Now it looks like we're really headed for the shoot out at O.K. Corral. There are those of us who question whether such large amounts of money are wisely spent in the chiropractic fight. But the fight against quackery remains a matter of principle. The only difference in 1978 will be that that principle will carry a higher price tag.

Are you getting any kind of impression as to whether or not you're getting your money's worth? There's no doubt in my mind. You are getting more than your money's worth. *This Society is active. It is aggressive.* It has moved from the defensive to the offensive.

If you think that Kelly has shot his wad, you're wrong. I'm not finished yet. I set out to do a lot. We did a lot. But there's still a lot to do.

There's still some work to be done in the malpractice battle. One of the areas in which we need to concentrate is that in which we must excel—lobbying. We need to take our legislative package up to the Hill and get the additional tort reforms still necessary. In this regard, time is our ally. Other professions are beginning to develop similar malpractice problems, not the least of which is the Bar itself. Industry is in deep trouble on product liability. This time we will not be alone.

Nor will we be without some very good ammunition. On August 24, the Gallup organization reported to the Board of Trustees on the results of their statewide survey of physicians to determine the extent of the malpractice crisis among the doctors of Pennsylvania.

We are now in a position to be able to statistically demonstrate to the legislators those areas in which the services to the public have been curtailed, those areas in which defensive medicine has dramatically increased the cost of care, and those areas where physicians have restricted or curtailed or even retired from practice because of the malpractice shadow. For the first time, we will have more than your opinion and my opinion when we lobby for the reforms still necessary.

In dealing with state government bureaucracy, I personally have told the commissioner of occupational affairs exactly what I think of his performance and what I expect to see the State Board of Medical Education and Licensure do. Of course it should not come as a surprise to you that I am no longer a member of the State Board of Medical Education and Licensure. There are those who think there is some connection between this and my removal from the state board.

I have met with the attorney general and I've asked him just where the two million dollars is which has been collected from doctors in this state. We are going to continue to ask this question until we get some reasonable answer from this administration and if that does not occur soon, we're going to talk to the press and other media and see if they can find out what's happened to that two million dollars. So far, it has not produced the new personnel or action needed at the state board.

Finally, I'm going to make a recommendation with regard to the State Board of Medical Education and Licensure. I think I'm qualified to make this recommendation having served eight years on it. Today, when a hospital medical staff or a county medical society or even an individual physician reports a wayward doctor to the State Board of Medical Education and Licensure, we are all sadly disappointed and disillusioned by its total lack of action.

Having served on that board, I understand the reasons for this apparent lack of action. Delay occurs because of due process safeguards built into Pennsylvania law; it occurs because of inexperienced attorneys working for the state; it occurs because of inadequate staff within the Justice Department and in the Bureau of Professional and Occupational Affairs itself.

Finally, it occurs because bureaucracy by its very nature tends to procrastinate. Bureaucrats find it far easier to do nothing and delay a decision than to do something.

But what about the rights of the rest of us? What about the rights of the hospital medical staff who reported the doctor? What about the rights of the county medical society members? What about the rights of the public who may be harmed by the wayward physician?

It seems to me that we, those of us who carry out our responsibilities conscientiously, that we, too, have some rights. And I believe the current system does not give us all our rights.

I therefore recommend legislation which would give the State Board of Medical Education and Licensure a reasonable amount of time in which to adjudicate complaints against doctors, perhaps 60 days with an extension of 30 days. But after that, the reporting group would have the right to go to Commonwealth Court to call for a show cause hearing why the license of the doctor under question should not be at least suspended until such time as his case is adjudicated by the State Board of Medical Education and Licensure.

I believe this is essential because under the current situation, the public has no right of appeal.

Well, there you have it. If you'll excuse the expression, it was a hell of a ride, but I enjoyed every minute of it. Some say the State Society will never be the same again. I certainly hope not and I hope you agree that you got your money's worth.

Speaking of money, just so you know where I stand before you leave this meeting, I want you to vote for a dues increase. I want you to support a dues increase because I think this is the kind of medical society that you want and that your members want.

I think this is the kind of medical society we can all be proud of, the kind that's involved, that's going after the enemies, that's attacking. To do the kind of things we're doing, to act the way we're acting takes money, but that doesn't bother me. I understand that and I'm ready to pay my way. I expect you and your members to do the same.

I want to close by thanking my wife and children for tolerating my being away from home. Incidentally I attended 148 meetings for this Society necessitating my being away from my practice 109 days.

Last year I was a little harsh on our staff. This year I can say that most of them busted their britches helping me on these programs.

To the Allegheny County Medical Society, George Rowland, Bill Ryan, the members of the Board, the many Johns and Bills who worked with me, and to this House, I can only say "thank you" for letting me serve as your president. It has added a new dimension to my career in medicine and has made me a better physician all around for having served you and this great medical society. □

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Proceedings
128th Annual Session of the House of Delegates
Lancaster, October 25-27, 1977

(Secretary's Note: Affirmative action by the House on the recommendations of the Reference Committees was taken unless otherwise specifically reported.)

Opening Session of the House
October 25, 1977

Dr. D. Ernest Witt, Speaker of the House, called the opening session of the House of Delegates to order at 1:20 p.m., Tuesday, October 25, 1977, in the Baroque Ballroom of the Host Farm Resort Motel, Lancaster. After receiving a report from the Chairman of the Committee on Credentials, indicating that a quorum was present, the Speaker called upon Reverend Francis Gilligan, former headmaster at the Malvern Preparatory School, Malvern, Pennsylvania, and currently involved in parochial duties at St. Rita's Roman Catholic Church of Philadelphia, to offer the invocation. Following the invocation, the Speaker indicated that delegates should be aware of Resolution 72-6 prohibiting smoking in the House of Delegates or reference committee hearings. The Speaker also requested that anyone presenting amendments to resolutions and motions prepare a written copy and deliver it to the rostrum.

COMMITTEE ON RULES

Harry L. Manning, M.D., Lycoming County, Chairman of the Committee on Rules, presented the following written report:

"Mr. Speaker and members of the House of Delegates: the Reference Committee on Rules met and unanimously approved the adoption of the Standing Rules of the House of Delegates of the Pennsylvania Medical Society as published on pages 7-8 of the 1977 Official Reports Book.

"Mr. Speaker, I recommend that the Standing Rules of the House of Delegates be adopted as presented."

A motion was made from the floor that the House of Delegates go into Executive Session for the next two days. This motion was defeated.

NECROLOGY REPORT

The House stood in tribute following the Necrology Report presented by George A. Rowland, M.D., Chairman of the Board of Trustees:

"At this time it is customary to ask you to give a moment's thought to our members who may have been with us here a year ago, but, in the past months, have responded to their last roll call. Their names have been memorialized in county medical society bulletins and in PENNSYLVANIA MEDICINE, the journal of the Pennsylvania Medical Society.

"From September 1, 1976 to August 31, 1977, we have lost by death 194 members: 9 not over 50 years of age; 82 between 51 and 70; and 103 in the group aged 71 to over 90. Of these 194 members, 91 were Associates, all of whom were 70 years of age or over. The Necrology Report at the last Annual Session reported the loss of 187 members.

"May we rise for this moment in silence and respect to those members who have passed to their eternal reward during the past year."

REPORT
PENNSYLVANIA MEDICAL POLITICAL ACTION COMMITTEE

Charles K. Zug, III, M.D., Northampton County, Chairman of the PaMPAC Board of Directors, presented an informational report to the House. Dr. Zug's report is included as Appendix A to these proceedings.

REPORT
PENNSYLVANIA MEDICAL COOPERATIVE

H. Robert Davis, M.D., Cumberland County, President of the Pennsylvania Medical Cooperative, presented a status report on the Co-op. This report is attached as Appendix B.

INTRODUCTIONS

D. Ernest Witt, M.D., Columbia County, Speaker of the House of Delegates, introduced officers of the Society and members of the Board of Trustees and Councilors.

APPROVAL OF PROCEEDINGS

The Proceedings of the 127th Annual Meeting of the Society held in Philadelphia, September 16-18, 1976, and found on pages 67-106 in the November 1976 issue of PENNSYLVANIA MEDICINE were approved. The Proceedings of the Special Session held in Camp Hill, April 17, 1977, and found on pages 53-56 in the June 1977 issue of PENNSYLVANIA MEDICINE were approved.

ADDRESS OF THE PRESIDENT

William J. Kelly, M.D., Allegheny County, President, presented a report on many areas in which the Society has been active during his tenure as President. The address, which was referred to the Reference Committee on Reports of Officers, appears elsewhere in this issue.

REPORT OF THE AMA DELEGATION

As required by the resolved portion of Resolution 71-1: AMA Delegation Report on Plans, the House received a brief report from Malcolm W. Miller, M.D., Philadelphia, Chairman of the PMS Delegation:

"Mr. Speaker, members of the House of Delegates:

"The complete report of the Pennsylvania Delegation to the American Medical Association appears on pages 82-84 of the Official Reports Book. At this time, I would like to reiterate those items which I believe should be emphasized.

"Ten delegates and nine alternate delegates attended the Thirtieth Annual Clinical Convention of the AMA which was held in Philadelphia in December 1976.

"The Pennsylvania Medical Society was represented by a full complement of delegates and alternate delegates at the AMA's Annual Meeting held in San Francisco, California, this past June. At this meeting, Dr. William Y. Rial of Swarthmore was elected Speaker of the AMA House of Delegates. In addition, Dr. James B. Snow of Philadelphia was re-elected to a position on the AMA's Council on Scientific Affairs.

"In addition to the above meetings, the Pennsylvania Delegation to the AMA held a caucus in April at the Hershey Convention Center in Hershey, Pennsylvania, to discuss the proposed schedule of activities for the AMA Annual Meeting.

"Four Pennsylvania resolutions were introduced at the December Clinical Convention. One resolution called for a 50% dues reduction for physicians in the first year of practice. The resolution was considered meritorious but was rejected due to the financial state of the AMA at that time.

"As called for by the 1976 House of Delegates, the Delegation introduced a resolution calling for the AMA to oppose any action to reduce fees paid for anesthesiologists or other physicians for services rendered by interns or residents under their direct supervision. This resolution was referred to the AMA Board of Trustees and, after study by the Council on Medical Service, the House, at its June meeting, reaffirmed current AMA policy on reimbursement to physicians for services rendered by interns or residents.

"The controversial expert witness resolution was withdrawn at the December 1976 meeting at the advice of AMA legal counsel. With slight rewording, it was re-introduced at the June meeting and, at that time, the AMA acted favorably on it. AMA policy now states that expert witnesses should be professionally qualified in the judgment of their peers to provide testimony in malpractice cases. In addition, the AMA expressed its concern over physicians who were hired as expert witnesses as part of their occupations and condemned those who give "false and misleading" testimony or misrepresent their qualifications. State medical associations were urged to seek legislative definition of expert witness, and county societies were urged to take legal action against physicians who are unethical in giving expert testimony in court actions.

"The AMA is currently working with the Secretary of Health, Education and Welfare and the Commissioner of the Social Security Administration to promote more widespread use of home dialysis as an alternative to hospital or free-standing facilities maintenance dialysis. This action came as a result of a resolution submitted by the Pennsylvania Delegation.

"By the way, all of these resolutions are outlined in detail in your Official Reports Book for future reference.

"Two Pennsylvania resolutions were introduced at the June Annual Meeting of the AMA, one of which I've already summarized, that being expert witness. The second resolution concerned residency programs and urged AMA support of a tenet that the residency program as an educational experience and not an employee/employer relationship. The issue was debated extensively on the floor of the House of Delegates before they agreed that residents can be both students and employees, thereby upholding current AMA policy.

"This year has most definitely been busy and productive. We are fortunate to have dedicated colleagues who attend meetings faithfully on our behalf. Since this is my last year with the Delegation, I would like to thank all of you for your input and support. I have thoroughly enjoyed my exposure to the national decision-making and legislative process, and I am secure in the knowledge that each one of us has the power to influence the future of American medicine.

"Thank you."

PENNSYLVANIA DELEGATION MEETING

It was announced that the Pennsylvania Delegation to the AMA would hold a business meeting Tuesday evening, October 25, at 7:00 p.m. in the Wood Room.

DISTINGUISHED GUESTS

The following distinguished guests were presented to the House: Dr. John R. Davis, President, Medical and Chirurgical Faculty of Maryland; Dr. Frank R. Began, President, Medical Society of New Jersey; Dr. Joseph A. Smith, President, West Virginia State Medical Association; Mr. Clive R. Waxman, Jr., Chairman of the Board, Hospital Association of Pennsylvania; and Miss Sandy Butkowski, CMA-AC, President, Pennsylvania Society, American Association of Medical Assistants.

ADDRESS OF THE PRESIDENT ELECT

John V. Blady, M.D., Philadelphia County, President Elect, presented a report on his plans for the upcoming year. Dr. Blady's address was referred to the Reference Committee on Reports of Officers. Specific recommendations include: re-examination of those activities of every council of the State Society within its purview which in any way relate to state government and assign to those activities that council's highest priority, with those councils coming back to the House of Delegates next year and, as the first order of business in their annual reports, explain how they have gone about achieving the objective of better interface with state government; specialty societies with economic and legislative problems bring them to the Pennsylvania Medical Society to seek the support of the entire house of medicine for their cause prior to starting independent actions which cause greater involvement than they foresaw and they produce difficulties in pursuing these activities; referred to an appropriate reference committee for consideration at this meeting the problem of specialty society representation and communication; assigned, by the Board, the health care cost issue to one of the councils or commissions of the Society, which should be responsible during the year for issuing information on ways of containing costs and be required to make a report to the House of Delegates next year. The text of Dr. Blady's address appears elsewhere in this issue.

ACCEPTANCE OF REPORTS AND RESOLUTIONS

The material contained in the 1977 Official Reports Book was presented for acceptance to the House.

ANNOUNCEMENT PENNSYLVANIA MEDICAL CARE FOUNDATION

The following announcement was made by the Speaker with regard to the Pennsylvania Medical Care Foundation: "As you know, according to the Bylaws of the Medical Care Foundation, members of the PMS House of Delegates are also the administrative members of the Pennsylvania Medical Care Foundation. The 1977 Annual Report of the Board of Directors of the Pennsylvania Medical Care Foundation has been previously mailed to you. If you need a copy of that report, which has been referred to the Reference Committee on Medical Service "B", copies are available at the Registration Desk.

"It is the recommendation of the Chair that the House determine to hold the annual meeting of the Pennsylvania Medical Care Foundation tomorrow afternoon. We recommend that immediately after concluding the Reference Committee on Reports of Officers, the House consider the Reference Committee Report of Medical Service "B". At the conclusion of Medical Service "B", we believe the House should recess and immediately reconvene the

meeting of the administrative members of the Foundation. Following the Annual Meeting of the Foundation, we would reconvene as the House of Delegates."

ADDRESS OF THE PRESIDENT PENNSYLVANIA MEDICAL CARE FOUNDATION

The Speaker called upon Sidney O. Krasnoff, M.D., Philadelphia County, President of the Pennsylvania Medical Care Foundation, for a few remarks concerning the Annual Report of the Foundation. His remarks were referred to the Reference Committee on Medical Service "B" and appear as Appendix C of these Proceedings.

SUPPLEMENTAL REPORTS

The following supplemental reports were contained in the Official Reports Book: Supplemental Report A, Committee on Medical Benevolence (referred to Reference Committee on Reports of Officers, see Appendix D); Supplemental Report A, Board of Trustees and Councilors (referred to Reference Committee on Reports of Officers except as noted, see Appendix E).

The following supplemental reports were contained in the Delegates' Packet: 1. Supplemental Report B, Report of the Board of Trustees and Councilors, pertaining to Society restructure (referred to Reference Committee on Reports of Officers, see Appendix F); Supplemental Report C, Report of the Board of Trustees and Councilors, pertaining to the relationship between PMS and PBS (referred to Reference Committee on Medical Service "A", see Appendix G); Supplemental Report E, Report of the Board of Trustees and Councilors, pertaining to implementation of 1976 House of Delegates recommendation 10.05 (referred to Reference Committee on Medical Service "B", see Appendix I); Supplemental Report, Council on Governmental Relations (referred to Reference Committee on Governmental Relations, see Appendix K); Supplemental Report, Council on Professional Relations and Services (referred to Reference Committee on Professional Relations and Services, see Appendix M).

The following supplemental reports were passed out during the meeting of the House of Delegates: 1. Supplemental Report D, Report of the Board of Trustees and Councilors, pertaining to PMSLIC (referred to Reference Committee on Medical Service "A", see Appendix H); Supplemental Report F, Report of the Board of Trustees and Councilors (referred to Reference Committee on Reports of Officers except as noted, see Appendix J); Supplemental Report, Council on Medical Service (referred to the Reference Committee on Medical Service "A", see Appendix L); Supplemental Report, Committee on Constitution and Bylaws (referred to Reference Committee on Constitution and Bylaws, see Appendix N); Supplemental Report, Reports of Individual Councilors, Tenth District, Lawrence County (referred to Reference Committee on Reports of Officers, see Appendix O); Report, Judicial Council (referred to Reference Committee on Reports of Officers, see Appendix P).

FINANCE COMMITTEE REPORT

Leroy A. Gehris, M.D., Berks County, Chairman of the Finance Committee, presented the following report of the Finance Committee of the Board of Trustees and Councilors:

"Mr. Speaker, members of the House of Delegates:

"A copy of the proposed budget for 1978 as tentatively approved by the Board of Trustees has been distributed for your information. It also contains a comparative figure for the budget approved for 1977, as well as the actual expenditures for the period January 1 through September 30, 1977, which shows a deficit of $135,198. We project a year-end deficit at this point of approximately $175,000. The main cause of this deficit is the Society's continued aggressive action to solve the professional liability insurance crisis. Expenses in this area will total approximately $300,000 this year. These funds have been used to oppose proposed rate increases and pay legal and actuarial fees, as well as sustain the Society's legal suit against the Argonaut Insurance Company. It also contains cost for defense against the Argonaut suit vs. PMS, as well as the expense for developing the settlement agreement which cleared the way for the activation of the Society's own insurance company.

"The 1978 budget as approved by the Board anticipates a deficit of $394,416 and is based on the current annual assessment of $150 per full dues-paying member. This budget was carefully reviewed by the Finance Committee upon two separate occasions before it was submitted to the Board. The budget contemplates continued aggressive action on the part of the Society to create a climate in Pennsylvania that will permit physicians to practice medicine according to the highest professional standards without interference from government. A few adjustments were made, but on balance, both the Committee and the Board feel that the request of the various councils, committees, and departments are reasonable and represent the monetary needs to carry out their mandated programs. Careful financial management has reached the administration of the Society's programs in the past. We expect the continued cooperation of all units of the Society in this respect.

"This budget is based on the assumption that the membership will pay the mandatory and selective assessments and thereby provide sufficient surplus for the insurance company to get its Certificate of Authority from the Insurance Department to commence this operation and that the terms of settlement agreement will be met by all the parties involved. If, however, the membership does not pay the assessment by the deadline of November 15 in sufficient numbers for the Society to go ahead with the insurance company, then the settlement agreement with Argonaut will be null and void and the situation will revert to its former condition. That will mean the legal suits will again be operative and that the Argonaut Insurance Company will continue to provide professional liability insurance to the members of the Pennsylvania Medical Society under the terms and conditions of the Society's current contract with Argonaut which expires May 31, 1979. Such a development could entail the necessity for Society intervention in Argonaut proposed rate increase hearings in 1978 if we believe those increases cannot be justified. This will involve considerable legal and actuarial expenses as it has in the past. The suits themselves, of course, will result in considerable legal expense. The Finance Committee estimates that this set of circumstances will involve additional expenditures of $225,000 which would create an estimated deficit of $619,416 in 1978. This deficit, of course, does not include any actions that the House of Delegates will take during the next three days with regard to the resolutions and recommendations before it.

"In the opinion of the Finance Committee, it will not be enough to balance the budget. This House of Delegates in 1974, at the time of the last dues increase, mandated a counter-offensive against the irresponsible use of the legal system in Pennsylvania. The House directed increased action to stem the arrogant encroachment of government into the practice of medicine. Commitments of this magnitude require large sums of money and real commitment on the part of every member of the Society. As you ponder this for the next few days, bear in mind that each $10 of dues will generate approximately $100,000 of income.

"That means it will take a $50 dues increase just to balance the present budget estimates.

"That means it will take at least a $60 dues increase to cover legal and actuarial expenses if the insurance company does not go.

"It could take a $100 dues increase to meet the expenses of the proposals before the House if they are approved.

"The Finance Committee will watch very carefully the actions taken in the next few days and will make a reassessment of the Society's needs in 1978 to determine the amount of increase needed to finance the Society's operation in 1978. I will return at the final session of the House of Delegates with a recommendation for 1978 dues. It will then be your decision.

"If there are any questions regarding the budget for 1978 or the financial condition of the Society, I recommend that you attend the hearing of the Reference Committee on Reports of Officers where members of the Finance Committee and others will be available to answer questions and hear your opinion.

"Thank you."

RESOLUTIONS

The following resolutions were received less than 30 days before the meeting of the House of Delegates and were accepted as the business of the House:

Resolution No. 77-9

(Referred to Reference Committee on Governmental Relations)
Subject: Liability for Development of Products to Reduce Health Hazards
Introduced By: Matthew Marshall, Jr., M.D., Allegheny County Medical Society
Author: Matthew Marshall, Jr., M.D.

Resolution No. 77-10

(Referred to Reference Committee on Governmental Relations)
Subject: Legal and Disciplinary Powers for County Medical Societies
Introduced By: Robert B. Stuart, M.D., Executive Secretary, on behalf of the Erie County Medical Society
Author: Robert B. Stuart, M.D., Executive Secretary, on behalf of the Erie County Medical Society

Resolution No. 77-11

(Referred to Reference Committee on Reports of Officers)
Subject: Commendation - William Y. Rial, M.D.
Introduced By: Wallace O. Lecher, Jr., M.D., Secretary, on behalf of the Delaware County Medical Society
Author: Wallace O. Lecher, Jr., M.D., Secretary, on behalf of the Delaware County Medical Society

Resolution No. 77-12

(Referred to Reference Committee on Reports of Officers)
Subject: PENNSYLVANIA MEDICINE
Introduced By: Wallace O. Lecher, Jr., M.D., Secretary, on behalf of the Delaware County Medical Society
Author: Wallace O. Lecher, Jr., M.D., Secretary, on behalf of the Delaware County Medical Society

Resolution No. 77-13

(Referred to Reference Committee on Constitution and Bylaws)
Subject: County Medical Society Membership
Introduced By: Wallace O. Lecher, Jr., M.D., Secretary, on behalf of the Delaware County Medical Society
Author: Wallace O. Lecher, Jr., M.D., Secretary, on behalf of the Delaware County Medical Society

Resolution No. 77-14

(Referred to Reference Committee on Medical Service "A")
Subject: Membership Benefit
Introduced By: Wallace O. Lecher, Jr., M.D., Secretary, on behalf of the Delaware County Medical Society
Author: Wallace O. Lecher, Jr., M.D., Secretary, on behalf of the Delaware County Medical Society

Resolution No. 77-15

(Referred to Reference Committee on Reports of Officers)
Subject: Pennsylvania Medical Society In-House Legal Counsel
Introduced By: Wallace O. Lecher, Jr., M.D., Secretary, on behalf of the Delaware County Medical Society
Author: Wallace O. Lecher, Jr., M.D., Secretary, on behalf of the Delaware County Medical Society

Resolution No. 77-16

(Referred to Reference Committee on Reports of Officers)
Subject: Countersuits
Introduced By: Wallace O. Lecher, Jr., M.D., Secretary, on behalf of the Delaware County Medical Society
Author: Wallace O. Lecher, Jr., M.D., Secretary, on behalf of the Delaware County Medical Society

Resolution No. 77-17

(Referred to Reference Committee on Medical Service "A")
Subject: Insurance Commissioner
Introduced By: Wallace O. Lecher, Jr., M.D., Secretary, on behalf of the Delaware County Medical Society
Author: Wallace O. Lecher, Jr., M.D., Secretary, on behalf of the Delaware County Medical Society

Resolution No. 77-18

(Referred to Reference Committee on Medical Service "B")
Subject: Interference with Professional Judgment of Physician
Introduced By: Milton M. Perloff, M.D., Philadelphia County Medical Society
Author: Milton M. Perloff, M.D., Philadelphia County Medical Society

Resolution No. 77-19

(Referred to Reference Committee on Medical Service "A")
Subject: Recommendations to Relieve the Malpractice Crisis
Introduced By: Eugene B. Rex, M.D., Otolaryngology & Maxillofacial Surgery
Author: Eugene B. Rex, M.D., Otolaryngology & Maxillofacial Surgery

Resolution No. 77-20

(Referred to Reference Committee on Reports of Officers)
Subject: Creation of an Additional Administrative Council
Introduced By: Henry H. Fetterman, M.D., Lehigh County
Author: Henry H. Fetterman, M.D., Lehigh County

Resolution No. 77-21

(Referred to Reference Committee on Education and Science)
Subject: Use of Anorexiants For Treatment of Obesity
Introduced By: John S. Parker, M.D., Westmoreland County Medical Society
Author: John S. Parker, M.D., Westmoreland County Medical Society

Resolution No. 77-22

(Referred to Reference Committee on Medical Service "A")
Subject: Surreptitious Argonaut Policyholders
Introduced By: Samuel S. Faris, II, M.D., Montgomery County
Author: Samuel S. Faris, II, M.D., Montgomery County

Resolution No. 77-23

(Referred to Reference Committee on Education and Science)
Subject: The Physician Assistant
Introduced By: Arlington A. Nagle, M.D., Secretary, on behalf of the Berks County Medical Society
Author: Arlington A. Nagle, M.D., Secretary, on behalf of the Berks County Medical Society

Resolution No. 77-24

(Referred to Reference Committee on Constitution and Bylaws)
Subject: Terms of Office of Trustees and Councilors and Designation of Councilor Districts
Introduced By: Harold E. Swensen, M.D., Secretary, on behalf of the Allegheny County Medical Society Delegation
Author: A. Linn Weigel, M.D., President, Allegheny County Medical Society

Resolution No. 77-25

(Referred to Reference Committee on Professional Relations and Services)
Subject: AMA Direct Membership Dues Billing
Introduced By: Montgomery County Medical Society Delegation
Author: Alan L. Dorian, M.D., Delegate, Montgomery County Medical Society

Resolution No. 77-26

(Referred to Reference Committee on Medical Service "A")
Subject: Collection of Dues From Non-Member Argonaut Policyholders
Introduced By: Montgomery County Medical Society Delegation
Author: Samuel F. Cohen, M.D., Delegate, Montgomery County Medical Society

Resolution No. 77-27

(Referred to Reference Committee on Medical Service "A")
Subject: Non-PMS Member Argonaut Policyholder
Introduced By: Montgomery County Medical Society Delegation
Author: Samuel F. Cohen, M.D., Montgomery County Medical Society

Resolution No. 77-28

(Referred to Reference Committee on Medical Service "A")
Subject: Interest Funds of Arbitration Panel
Introduced By: Montgomery County Medical Society Delegation
Author: Edgar W. Kline, M.D., Delegate, Montgomery County Medical Society

Resolution No. 77-29

(Referred to Reference Committee on Medical Service "A")
Subject: Locale of Malpractice Incidents
Introduced By: Montgomery County Medical Society Delegation
Author: Samuel S. Faris, II, M.D., Delegate, Montgomery County Medical Society

Resolution No. 77-30

(Referred to Reference Committee on Governmental Relations)
Subject: AMA Support of National Health Insurance/Care Legislation
Introduced By: Harold J. Byron, M.D., Delegate, Montgomery County Medical Society
Author: James L. Pendleton, M.D., Member, Montgomery County Medical Society

Resolution No. 77-31

(Referred to Reference Committee on Medical Service "B")
Subject: Blue Shield's Vision and Hearing Care Program for United Auto Workers
Introduced By: David A. Smith, M.D., Secretary-Treasurer, on behalf of Dauphin County Medical Society
Author: Ronald M. Grossman, M.D.

Resolution No. 77-32

(Referred to Reference Committee on Medical Service "A")
Subject: Medical Malpractice Arbitration Fund
Introduced By: Wallace O. Lecher, Jr., M.D., Secretary, on behalf of the Delaware County Medical Society
Author: Wallace O. Lecher, Jr., M.D.

Resolution No. 77-33

(Referred to Reference Committee on Constitution and Bylaws)
Subject: Pennsylvania Medical Society Councilor Districts
Introduced By: Wallace O. Lecher, Jr., M.D., Secretary, on behalf of the Delaware County Medical Society
Author: Wallace O. Lecher, Jr., M.D.

Resolution No. 77-34

(Referred to Reference Committee on Medical Service "A")
Subject: Report of the 1006 Joint Committee
Introduced By: Wallace O. Lecher, Jr., M.D., Secretary, on behalf of the Delaware County Medical Society
Author: Wallace O. Lecher, Jr., M.D.

Resolution No. 77-35

(Referred to Reference Committee on Reports of Officers)
Subject: Reports of Individual Councilors
Introduced By: Wallace O. Lecher, Jr., M.D., Secretary, on behalf of Delaware County Medical Society
Author: Wallace O. Lecher, Jr., M.D., Secretary

Resolution No. 77-36

(Referred to Reference Committee on Medical Service "A")
Subject: PMSLIC Board of Directors
Introduced By: Wallace O. Lecher, Jr., M.D., Secretary, on behalf of Delaware County Medical Society
Author: Wallace O. Lecher, Jr., M.D., Secretary

Resolution No. 77-37

(Referred to Reference Committee on Medical Service "A")
Subject: Professional Liability Insurance
Introduced By: Wallace O. Lecher, Jr., M.D., Secretary, on behalf of Delaware County Medical Society
Author: Wallace O. Lecher, Jr., M.D., Secretary

Resolution No. 77-38

(Referred to Reference Committee on Medical Service "B")
Subject: Criteria for Need of Computerized Axial Tomography Units
Introduced By: Aureliano Rivas-Flores, Jr., M.D., Delegate, Montgomery County Medical Society
Author: Aureliano Rivas-Flores, Jr., M.D., Delegate, Montgomery County Medical Society

Resolution No. 77-39

(Referred to Reference Committee on Medical Service "B")
Subject: Increased Paperwork Requirements by the Department of Public Welfare
Introduced By: Joseph N. Sienkiewicz, M.D., on behalf of the Northumberland County Medical Society
Author: Joseph M. Sienkiewicz, M.D., President, Northumberland County Medical Society

Resolution No. 77-40

(Referred to Reference Committee on Reports of Officers)
Subject: Commendation of Pennsylvania Insurance Commissioner
Introduced By: William J. Pherson, M.D., Delegate, Butler County Medical Society
Author: William J. Pherson, M.D., Delegate, Butler County Medical Society

Resolution No. 77-41

(Referred to Reference Committee on Medical Service "B")
Subject: Blue Shield's Vision and Hearing Care Program for United Auto Workers
Introduced By: Paul A. Cox, M.D., Specialty Delegate from the Pennsylvania Academy of Ophthalmology and Otolaryngology
Author: Paul A. Cox, M.D.

Resolution No. 77-42

(Referred to Reference Committee on Education and Science)
Subject: Community Mental Health Centers
Introduced By: Robert S. Pressman, M.D., Philadelphia County Medical Society
Author: Bernard M. Blum, M.D., Philadelphia County Medical Society

Resolution No. 77-43

(Referred to Reference Committee on Medical Service "A")
Subject: Frank B. Hall & Company, Inc., of Pennsylvania
Introduced By: Howard A. Richter, M.D., Delaware County
Author: Howard A. Richter, M.D.

Resolution No. 77-44

(Referred to Reference Committee on Education and Science)
Subject: Preparation of Minorities for Medical School Admission
Introduced By: George A. Tushim, M.D., on behalf of the Clinton County Medical Society
Author: George A. Tushim, M.D.

REFERENCE COMMITTEES

Reference Committees for the 1977 Annual Session of the House of Delegates are listed below:

Constitution and Bylaws

*Betty L. Cottle (Blair) Chairman
*Frederick G. Brown (Montour)
*Charles A. Heisterkamp, III (Lancaster)
*Joseph B. Blood, Jr. (Bradford)
*John P. Whiteley (York)
Robert M. Jaeger (Lehigh) Alternate

Credentials

Joseph M. Sienkiewicz (Northumberland) Chairman
David L. Miller (Clarion)
Igor I. Islamoff (Cambria)
Ronald A. Deitrick (Blair)
Max L. Ronis (Philadelphia)

Education and Science

*William J. West (Cumberland) Chairman
*George A. Tushim (Clinton)
*John M. Rathgeb (Westmoreland)
*Aureliano Rivas-Flores, Jr. (Montgomery)
*Bernard B. Zamostein (Philadelphia)
Clayton C. Barclay (Schuylkill) Alternate

Governmental Relations

*Donald G. Crawford (Dauphin) Chairman
*Robert N. Moyers (Crawford)
*William H. Kittrell (Washington)
*Edward J. Resnick (Philadelphia)
*John Y. Templeton, III (Philadelphia)
William R. A. Boben (Lancaster) Alternate

Medical Service "A"

*R. Robert Tyson (Philadelphia) Chairman
*James F. Welsh (Berks)
*Robert E. Gregory (Allegheny)
*J. Scott Homer, Jr. (Blair)
*David P. Morrison, Jr. (Bucks)
William A. Shaver (Lebanon) Alternate

Medical Service "B"

*Roderick R. McLeod (Armstrong) Chairman
*John Helwig, Jr. (Philadelphia)
*James R. Dornenberg (Allegheny)
*Arlington A. Nagle (Berks)
*Charles A. Bikle (Franklin)

Professional Relations and Services

*Arthur J. Patterson (Greene) Chairman
*Donald E. Parlee (Bucks)
*Frank M. Tooze (Erie)
*Ronald Krablin (Adams)
*Harry C. Stamey (Montour)
Thomas E. Patrick (Columbia) Alternate

Reports of Officers

*Stephen I. Dodd (Mifflin-Juniata) Chairman
*Conrad A. Etzel (Delaware)
*Jon S. Adler (Washington)
*Frank W. Jackson (Dauphin)
*Samuel S. Faris (Montgomery)
William J. Pherson (Butler) Alternate

Rules

*Harry L. Manning (Lycoming) Chairman
*Harmon J. Machanic (Lycoming)
*Carmela S. Lugue (Clearfield)
*Frans J. Vossenberg (Montgomery)
*John L. Kelly (Delaware)

Tellers

Nancy M. Swensen (Allegheny) Chairman
John H. Shugert (Beaver)
William C. Long (Clinton)
Leon N. Branton (Lehigh)
Paul R. Woolslayer (Somerset)
Eugene B. Rex (Mongomery)

**Indicates those members who signed the report.*

Alternates to reference committees — Again this year the Speaker appointed an alternate member to serve with each reference committee. The alternates were so notified and received all pertinent materials relating to the reference committee. The purpose of this procedure is to make available to the committee a substitute familiar with the business of the committee in the event that one of the regular committee members is unable to serve.

REMARKS OF PRESIDENT OF AMA AUXILIARY

Mrs. Chester L. Young, President of the American Medical Association Auxiliary, addressed the House. Her remarks were received for information.

REMARKS OF PRESIDENT OF AUXILIARY

Mrs. Spencer J. Servoss, President, Pennsylvania Medical Society Auxiliary, addressed the House and reported on the activities of the Auxiliary. Her remarks were referred to the Reference Committee on Professional Relations and Services and are available upon request.

COUNCILOR DISTRICT CAUCUSES

The Speaker announced that Councilor District Caucuses would be held Wednesday morning beginning at 10:30 a.m. It was also noted that specialty and AMSA delegates would caucus at 9:30 a.m. on that same day. On Thursday morning, further time was reserved for additional Councilor District Caucuses beginning at 8:30 a.m., with the specialty and AMSA caucus beginning at 8:00 a.m. Copies of reference committee reports were made available at the caucuses.

RECESS

The House of Delegates was recessed at 3:40 p.m. until 1:00 p.m. Wednesday afternoon.

The Second Session of the House
October 26, 1977

The second session of the House of Delegates was called to order at 1:20 p.m. in the Baroque Ballroom of the Host Farm Resort

Motel, Lancaster. Joseph M. Sienkiewicz, M.D., Northumberland County, Chairman, Committee on Credentials, reported that a quorum was present.

It was noted that Elk-Cameron, Potter, Susquehanna, and Wyoming Counties were without representation in the House of Delegates. The Vice Speaker noted that Article VI, Section 3 of the Constitution states that: "If any component society is without any duly accredited voting member of the House of Delegates at any session thereof, then the active, senior active, intern or resident member or members registered in attendance from that component society may select himself or one delegate from their number, as the case may be, who shall be the representative of that component society and shall serve in the place of an accredited delegate." The Vice Speaker again reminded the delegates of Resolution 72-6 prohibiting smoking in the House of Delegates or reference committee hearings.

REFERENCE COMMITTEE CONSTITUTION AND BYLAWS

Betty L. Cottle, M.D. (Blair), chairman, presented the following report to the Committee.

Mr. Speaker, and members of the House of Delegates, the Reference Committee on Constitution and Bylaws has considered the material listed in the Index and presents the following report:

1. Unified Membership (pages 2 and 54 of the Official Reports Book)

On recommendation of the reference committee, the House of Delegates in 1976 delayed voting on language to implement unified membership. The standing committee on Constitution and Bylaws was charged with preparing suitable language to implement unified membership, which appears on page 2 of the Official Reports Book. However, the preponderance of testimony before the reference committee was against mandatory unified membership at this time.

Mr. Speaker, we recommend a negative vote on the constitutional change regarding unified membership. *(Secretary's Note: Two-thirds vote required to amend the Constitution.)*

Mr. Speaker, we recommend a negative vote on the Bylaws change regarding unified membership. *(Secretary's Note: Three-fourths required to amend the Bylaws.)*

The Committee also heard testimony on Resolution 77-13, which addresses the subject of mandatory unified membership. The majority of the discussion favored encouragement of voluntary membership in the AMA. The author of the resolution also approved amending the first WHEREAS as follows: "WHEREAS, Some physicians have not been able to identify their interests with the AMA and"

Mr. Speaker, we recommend adoption of Resolution 77-13 as amended. *(Secretary's Note: Two-thirds vote required.)*

2. Associate Members: Licenses Not Required (pages 2 and 55 of the Official Reports Book)

The Reference Committee heard no testimony on the proposed Bylaws change which removes the requirement that Associate members maintain a license in order to continue their Pennsylvania Medical Society membership, particularly in light of the increased costs of licensure, and mandated malpractice insurance coverage.

Mr. Speaker, we recommend approval of the constitutional change regarding Associate members not being required to maintain their licenses. *(Secretary's Note: Two-thirds vote required.)*

3. County Society Executives' Membership (pages 2 and 55 of the Official Reports Book)

The 1976 House of Delegates adopted Resolution 76-7, which recommends that county medical society executives be eligible for affiliate membership in the Pennsylvania Medical Society. The reference committee heard favorable testimony regarding this proposed language change.

Mr. Speaker, we recommend approval of the constitutional change which makes county medical society executives eligible for affiliate membership in the Pennsylvania Medical Society. *(Secretary's Note: Two-thirds vote required.)*

4. Dues Reduction For First Year Members (pages 2-3 and 55 of the Official Reports Book; Report of Council on Professional Relations and Services, page 77)

The 1976 House of Delegates adopted Resolution 76-16, which allows a 50 percent reduction of dues for active members in their first full calendar year of practice following completion of a training program. The reference committee also noted the support of the Council on Professional Relations and Services as contained on page 77 of the Official Reports Book.

Mr. Speaker, we recommend approval of the constitutional change which permits a 50 percent dues reduction for active members in their first full calendar year of practice following completion of a training program. *(Secretary's Note: Two-thirds vote required.)*

5. Composition of Councilor District Board of Censors (pages 3 and 55 of the Official Reports Book)

The Reference Committee heard no discussion regarding the proposed Bylaws change which would prohibit members of the District Board of Censors from being concurrent members of the County Board of Censors or Grievance Committee.

Mr. Speaker, we recommend approval of the Bylaws change which prohibits a member on a District Board of Censors from also being a member of the County Board of Censors or Grievance Committee. *(Secretary's Note: Three-fourths vote required.)*

6. Publication of Proceedings (Supplemental Board Report A - portion on publishing Proceedings, page 85 of the Official Reports Book)

The matter of eliminating the mandatory publication of Proceedings has been recommended by the Board of Trustees. The reference committee studied Chapter III, Section 11 of the Bylaws and determined the following language changes to appropriately amend the Bylaws:

Section 11 - PUBLICATION OF PROCEEDINGS. The Proceedings of the House of Delegates at the Annual Session, or any special session [shall] *may* be published in the JOURNAL in the first possible issue following the Session except that Proceedings of Closed and Executive Sessions shall not be published. *If the Proceedings are not published, a full report of the Session shall be available on request to members.*

(Words in italics are being added. Words in brackets are being deleted.)

Mr. Speaker, we recommend approval of the Bylaws changes which eliminate mandatory publication of Proceedings of Sessions of the House of Delegates. *(Secretary's Note: Three-fourths vote required.)*

(*Secretary's Note:* The recommendation of the reference committee was not adopted. The following amendment to the recommendation reads as follows: "Section 11 - PUBLICATION OF PROCEEDINGS. The Proceedings of the House of Delegates at the Annual Session, or any special session, [shall] *may* be published in the JOURNAL in the first possible issue following the Session [except that Proceedings of Closed and Executive Sessions shall not be published]. *If the Proceedings are not published, a full report of the Session shall be available on request to members. Proceedings of Closed and Executive Sessions shall not be recorded.*

A vote was taken and passed to reject the recommendation for a Bylaws change eliminating mandatory publication of Proceedings of Sessions of the House of Delegates.)

7. Reinstate Associate Member As A Full Member (page 88 of the Official Reports Book; Resolution 77-2)

Resolution 77-2
Subject: Reinstatement of Associate Members as a Full Member
Introduced by: Henry H. Fetterman, M.D., on behalf of the Lehigh County Medical Society; David A. Smith, M.D., on behalf of the Dauphin County Medical Society
Author: Henry H. Fetterman, M.D., David A. Smith, M.D.

WHEREAS, Pennsylvania Medical Society is concerned in representing all physicians; and

WHEREAS, Pennsylvania Medical Society has included interns and residents as full members with the right to hold office and serve on councils and commissions; and

WHEREAS, Pennsylvania Medical Society has disenfranchised the associate member, who has long been a dues paying member, while still requiring him to maintain his proficiency with the CME requirement; and

WHEREAS, The associate member does not now count in determining delegate strength to the Pennsylvania Medical Society or to the American Medical Association; therefore be it

RESOLVED, That the associate member be reinstated as a full member, eligible to all the rights and privileges of full membership and proportionate representation to the Pennsylvania Medical Society and to the American Medical Association. *(Financial Note: No financial impact.)*

In the discussion regarding the reinstatement of associate members as full members, many questions were raised concerning the impact Resolution 77-2 would have on the current status of associate members as delineated in the Constitution and Bylaws. The reference committee felt that study of the issues and their ramifications is needed before any action is taken.

Mr. Speaker, we recommend Resolution 77-2 regarding the associate member category be referred to the Board of Trustees for further study.

8. Redistricting of Councilor Districts and Terms of Office (Supplemental Report of the Committee on Constitution and Bylaws, distributed; Resolution 77-24, distributed; Resolution 77-33, distributed)

Resolution 77-24
Subject: Terms of Office of Trustees and Councilors and Designation of Councilor Districts
Introduced by: Harold E. Swensen, M.D., Secretary, on behalf of the Allegheny County Medical Society Delegation
Author: A. Linn Weigel, M.D., President, Allegheny County Medical Society

WHEREAS, Trustees and Councilors of the Pennsylvania Medical Society currently are elected to serve terms of five years; and

WHEREAS, They are limited to two consecutive terms; and

WHEREAS, It may be more appropriate to consider a term of office of three years in order to effect greater involvement and participation of members; and

WHEREAS, It may be possible to redesignate councilor districts to more effectively and expeditiously represent the membership of the Pennsylvania Medical Society; therefore be it

RESOLVED, That the Board of Trustees of the PMS study and conduct a reappraisal of the Bylaws with respect to the terms of office of trustees and councilors and the designation of councilor districts and report to the House of Delegates.

(Financial Note: No financial impact.) Requires two-thirds vote.

Resolution 77-33
Subject: Pennsylvania Medical Society Councilor Districts
Introduced by: Wallace O. Lecher, Jr., M.D., Secretary, on behalf of the Delaware County Medical Society
Author: Wallace O. Lecher, Jr., M.D.

WHEREAS, The Secretary of Health, Education and Welfare has designated 12 PSRO areas in the Commonwealth of Pennsylvania; and

WHEREAS, These area determinations were accomplished with the cooperation and assistance of the Pennsylvania Medical Society, the individual county medical societies, and the Pennsylvania Medical Care Foundation; and

WHEREAS, These 12 areas were established using the criteria of physician population, hospital location, nursing home location, and medical marketing; therefore be it

RESOLVED, That the House of Delegates request the Board of Trustees of the Pennsylvania Medical Society to consider referring to the Committee on Long Range Planning or the Committee on Objectives to study the recommendation that the Pennsylvania Medical Society consider restructuring the present 12 PMS councilor districts to coincide with the 12 PSRO areas.

(Financial Note: No financial impact.) Requires two-thirds vote.

For purposes of convenience, the reference committee considered the question of redistricting of councilor districts as presented in the supplemental report and in Resolution 77-24 and 77-33 together because of similarity of content.

The reference committee heard discussion both for and against redistricting of councilor districts. The majority of the testimony favored the undertaking of a study on this issue as opposed to adopting a specific recommendation regarding the way in which councilor districts should be realigned.

Testimony was also heard in favor of studying the language of terms of office for trustees and councilors with a view of the possible reduction of terms.

Mr. Speaker, we recommend rejection of Resolution 77-33, which calls for realignment of councilor districts along PSRO lines.

Mr. Speaker, we recommend adoption of Resolution 77-24, which calls for the Board of Trustees to reappraise the Bylaws with respect to terms of office of trustees and councilors and redesignation of councilor districts, and report back to the House of Delegates.

REFERENCE COMMITTEE REPORTS OF OFFICERS

Stephen I. Dodd, M.D. (Mifflin-Juniata), chairman, presented the following report of the Committee.

Mr. Speaker and members of the House of Delegates, the Reference Committee on Reports of Officers has considered all of the items in the Index.

1. Your Reference Committee has grouped the following items together in a waiver of debate list. In each instance, there was little or no testimony heard and the Committee feels the items are of a non-controversial nature.

Waiver of Debate

Report of Executive Vice President (Official Reports Book, pages 32-33) (File)
Report of Accountant (Official Reports Book, pages 36-37) (File)
Report, Committee on Discipline (Official Reports Book, page 55) (File)
Report of Committee on Medical Benevolence (Official Reports Book, page 56) (File)
Report, Committee on Medicine, Religion, and Bioethics (Official Reports Book, pages 56-57) (File)
Report, Committee to Study Relations Between Medicine and Osteopathy (Official Reports Book, page 57) (File)
Report, Pennsylvania Delegation to the AMA (Official Reports Book, pages 82-84) (File)
Supplemental Report, Committee on Medical Benevolence (Official Reports Book, page 84) (File)
Supplemental Report, Report of Individual Councilors, Tenth Councilor District, Lawrence County (Delegates' Packets) (File)
Report of Judicial Council (Delegates' Packets) (File)

Mr. Speaker, your reference committee recommends that the above items be filed.

2. Resolution 77-11
Subject: Commendation - William Y. Rial, M.D.
Introduced by: Wallace O. Lecher, Jr., M.D., Secretary, on behalf of the Delaware County Medical Society
Author: Wallace O. Lecher, Jr., M.D., Secretary, on behalf of the Delaware County Medical Society

WHEREAS, As one of our senior members has been elected to the high office of Speaker of the AMA House of Delegates; therefore be it

RESOLVED, That this House of Delegates join with the Delaware County Medical Society in taking particular pleasure in congratulating William Y. Rial, M.D. in bringing this honor to the physicians of Pennsylvania.

(Financial Note: No financial impact.) Requires two-thirds vote.

Resolution 77-12
Subject: PENNSYLVANIA MEDICINE
Introduced by: Wallace O. Lecher, Jr., M.D., Secretary, on behalf of the Delaware County Medical Society
Author: Wallace O. Lecher, Jr., M.D., Secretary, on behalf of the Delaware County Medical Society

WHEREAS, The costs of publishing, distribution, and postage have risen due to the inflationary stage of our present economy; and

WHEREAS, The content and layout of PENNSYLVANIA MEDICINE have continued at a level of excellence; and

WHEREAS, PENNSYLVANIA MEDICINE is the major source of communication to all dues and non-dues paying members of the Pennsylvania Medical Society; therefore be it

RESOLVED, That the House of Delegates join with the Delaware County Medical Society in taking particular pleasure in commending the editor, Publication Committee, contributing editors, and staff of PENNSYLVANIA MEDICINE for their continued excellence.

(Financial Note: No financial impact.) Requires two-thirds vote.

Mr. Speaker, your reference committee recommends that the above resolutions be adopted.

3. Report of the Board of Trustees and Councilors, Recommendation Regarding Convention Site for 1982 (Official Reports Book, page 27); Supplemental Report F, Board of Trustees and Councilors, section dealing with date change for 1982 Annual Business Session (distributed)

Because of their related subject matter, the reference committee considered the above items concurrently.

The Board of Trustees has recommended that the 1982 Annual Business Session be held at the Host Farm Resort Motel, Lancaster, October 18-21.

Considerable testimony was heard which expressed the desire that the House rescind its 1973 directive that restricts Annual Business Sessions to the Harrisburg-Lancaster area.

Mr. Speaker, your reference committee recommends rejection of recommendation of the Board of Trustees concerning the site for the 1982 Annual Business Session.

Mr. Speaker, your reference committee recommends that the House of Delegates rescind its 1973 directive regarding location of Annual Business Sessions.

Mr. Speaker, your reference committee further recommends that the Board of Trustees and Councilors be instructed to report to the 1978 House of Delegates with appropriate meeting location recommendations for both 1982 and the subsequent year.

4. Report of the Board of Trustees and Councilors, Recommendation to eliminate committee on objectives (Official Reports Book, page 28); Report, Committee on Objectives (Official Reports Book, page 56)

Because of the similar nature of the items listed above, the reference committee considered them as one item. Both the Board of Trustees and Councilors and the Committee on Objectives have recommended that the Committee on Objectives be abolished. No testimony to the contrary was heard at the reference committee hearing.

Mr. Speaker, your reference committee recommends that the Committee on Objectives be abolished.

Mr. Speaker, your reference committee recommends that the remaining sections of the report of the Committee on Objectives be filed.

5. Report of the Board of Trustees and Councilors, Recommendation to abolish individual trustee reports (Official Reports Book, page 28)

Individual reports of trustees and councilors, Second District, recommendation to discontinue individual reports of trustees and councilors (Official Reports Book, page 42)

Resolution 77-35: Reports of Individual Councilors
Subject: Reports of Individual Councilors
Introduced by: Wallace O. Lecher, Jr., M.D., Secretary, on behalf of the Delaware County Medical Society
Author: Wallace O. Lecher, Jr., M.D., Secretary

WHEREAS, Dr. Leroy A. Gehris has demonstrated responsive leadership in his reporting of the activities of the county medical societies and the Second Councilor District; therefore be it

RESOLVED, That he continue to report the activities of the county medical societies of the Second Councilor District and the reports of individual councilors in the Official Reports Book to the House of Delegates, Pennsylvania Medical Society, and this House of Delegates urge all other trustees and councilors be requested to make similar reports.

(Financial Note: No financial impact.) Requires two-thirds vote.

Because of the similar nature of the items listed above, the reference committee considered them at the same time. Both the report of the Board of Trustees and Councilors and the report of the Second Councilor District trustee and councilor have called for the discontinuation of individual annual reports of trustees and councilors. Resolution 77-35 calls for the Second Councilor District trustee to continue the annual reporting of activities of his county medical societies of the Second Councilor District specifically and, in addition, recommends that the House of Delegates urge all other trustees and councilors make similar reports. Testimony at the reference committee hearing by authors of the report in question support the discontinuation of the reports; however, your reference committee feels that these reports have merit and should be continued.

Mr. Speaker, your reference committee recommends rejection of the recommendations contained in the report of the Board of Trustees and the individual report of the trustee of the Second Councilor District.

Mr. Speaker, your reference committee further recommends the adoption of Resolution 77-35.

6. Report of the Board of Trustees and Councilors (Official Reports Book, pages 14-31)

Your reference committee reviewed all sections of the Board's comprehensive report that were not previously considered.

Mr. Speaker, your reference committee recommends that the report of the Board of Trustees and Councilors be filed.

7. Individual Reports from Trustees and Councilors (Official Reports Book, pages 41-52)

Your reference committee reviewed the individual reports of the trustees and councilors. Special note was taken on the report of the trustee and councilor of the Second District (page 42). The trustee and councilor suggested that consideration be given by an appropriate body of the Society to study the possibility of discontinuing the "obsolete office of councilor." Testimony at the reference com-

mittee hearing was not in support of this recommendation.

Mr. Speaker, your reference committee recommends rejection of the recommendation which requested the discontinuation of the term "councilor."

Mr. Speaker, your reference committee further recommends that the remaining individual annual reports from trustees and councilors be filed.

8. Report of the Treasurer (Official Reports Book, page 35)

During a discussion of the financial status of the Society, a majority of physicians spoke in support of a 1978 dues increase, noting that in view of the Society's extensive activities, an increase in dues would be justified.

Mr. Speaker, your reference committee recommends that the report of the Treasurer be filed.

9. Report of the Committee on Relationships with Allied Professions (Official Reports Book, page 56)

The reference committee, in reviewing this report, noted that the concerns originally addressed by this committee are now being handled in greater detail and breadth elsewhere and that the need for this committee no longer exists. Testimony at the reference committee hearing supported the dissolution of this committee.

Mr. Speaker, your reference committee recommends that the Committee on Relationships with Allied Professions be abolished.

Mr. Speaker, your reference committee further recommends that the remainder of the report of the Committee on Relationships with Allied Professions be filed.

10. Supplemental Report A, Board of Trustees and Councilors (Official Reports Book, pages 84-87)

The Board of Trustees and Councilors requested that the House of Delegates consider the submission of three resolutions to the AMA at its upcoming clinical convention. Testimony at the reference committee hearing supported the submission of these resolutions dealing with quackery.

Mr. Speaker, your reference committee therefore recommends the following: (1) that the resolution which calls for the activation of an AMA committee on quackery be submitted to the AMA; (2) that the resolution recommending establishment of a nationwide quackery defense fund be submitted to the AMA; (3) that the resolution calling for the reestablishment of the AMA Department of Investigation be submitted to the AMA.

Mr. Speaker, your reference committee further recommends that the remainder of Supplemental Report A of the Board of Trustees and Councilors be filed.

11. Resolution 77-1: Establishment of a Legal Division Within the Pennsylvania Medical Society (Official Reports Book, page 88)

Subject: Establishment of Legal Division Within the Pennsylvania Medical Society

Introduced by: David N. Farber, M.D., on behalf of the Berks County Medical Society

Author: David N. Farber, M.D., on behalf of the Berks County Medical Society

WHEREAS, The medical malpractice crisis has not abated but rather has intensified; and

WHEREAS, Incursions into medical practice, by government and other entities, has become more frequent and will continue to do so; and

WHEREAS, It is vital to the Society to assure the continued excellence of medical practice, by vigilance and prompt action where necessary; and

WHEREAS, A major portion of that vigilance and action requires legislative expertise without a conflict of interest; therefore be it

RESOLVED, That a legal division of the Pennsylvania Medical Society be established and staffed with personnel responsible only to the Society.

(Financial Note: Undetermined.)

Resolution 77-15: Pennsylvania Medical Society In-House Legal Counsel (Delegates' Packets)

Subject: Pennsylvania Medical Society In-House Legal Counsel

Introduced by: Wallace O. Lecher, Jr., M.D., Secretary, on behalf of the Delaware County Medical Society

Author: Wallace O. Lecher, Jr., M.D., Secretary, on behalf of the Delaware County Medical Society

WHEREAS, The American Medical Association maintains an in-house legal counsel division responsible *only* to the American Medical Association Board of Trustees; and

WHEREAS, Possible anti-trust actions, malpractice legislation, health and welfare legislation, FTC intrusions, HMO, PSRO and HSA legal problems will be confronting organized medicine in the near future; therefore be it

RESOLVED, That the House of Delegates recommend to the Pennsylvania Medical Society Board of Trustees to consider the feasibility of establishing an in-house legal counsel responsible *only* to the Pennsylvania Medical Society Board of Trustees.

(Financial Note: Financial impact undetermined.) Requires two-thirds vote.

Because of the similar nature of the items above, the reference committee considered them at the same time. These resolutions prompted considerable debate. Although the reference committee is in sympathy with the intent of these resolutions, it is felt that both are too restrictive and would not be in the best interest of the Society at this time. However, the reference committee is in favor of the addition of a lawyer to the PMS staff and feels that this is a matter for consideration and implementation by the Board of Trustees.

Mr. Speaker, your reference committee recommends that Resolution 77-1 be rejected.

Mr. Speaker, your reference committee recommends that Resolution 77-15 be rejected.

Mr. Speaker, your reference committee further recommends that the matter of adding a lawyer to the PMS staff be referred to the Board of Trustees and Councilors.

12. Resolution 77-16: Countersuits (Delegates' Packets)

Subject: Countersuits

Introduced by: Wallace O. Lecher, Jr., M.D., Secretary, on behalf of the Delaware County Medical Society

Author: Wallace O. Lecher, Jr., M.D., Secretary, on behalf of the Delaware County Medical Society

WHEREAS, The membership of PMS was notified in the December 1976 PMS "Executive Report" 76-19 that PMS is helping doctors countersue attorneys who file frivolous malpractice suits against them; and

WHEREAS, The Illinois State Medical Society prepared an outstanding brochure, dated September 1976 entitled "Moves to Counter Litigation"; therefore be it

RESOLVED, That the House of Delegates request the Board of Trustees report the status of the countersuits filed in Pennsylvania on behalf of sufficient membership in Pennsylvania Medical Society.

(Financial Note: No financial impact.) Requires two-thirds vote.

Your reference committee feels that the section of Supplemental Report F of the Board of Trustees and Councilors entitled "Countersuits" satisfactorily addressed the intent of this resolution.

Mr. Speaker, your reference committee recommends that Resolution 77-16 be filed.

13. Supplemental Report B, Board of Trustees and Councilors (Delegates' Packets); Recommendation concerning Committee on Medicine, Religion, and Bioethics; Recommendation concerning Committee to Study Relations between Medicine and Osteopathy; Recommendation concerning Committee on Discipline.

The reference committee heard testimony in support of the Board's recommendation to discontinue the present Committee on Medicine, Religion, and Bioethics and to create a commission under the auspices of the Council on Education and Science to handle the present Committee's functions.

Mr. Speaker, your reference committee recommends that the Committee on Medicine, Religion, and Bioethics be discontinued.

Mr. Speaker, your reference committee further recommends that a commission be created under the Council on Education and Science to handle the present functions of the Committee on Medicine, Religion, and Bioethics.

The reference committee heard testimony in support of abolishing the Committee to Study Relations Between Medicine and Osteopathy since the Committee has been inactive for a number of years and liaison with the Osteopaths is being carried on in a satisfactory manner.

Mr. Speaker, your reference committee recommends that the Committee to Study Relations Between Medicine and Osteopathy be abolished.

The reference committee considered the recommendation of the Board of Trustees which would eliminate the Committee on Discipline. Testimony at the reference committee hearing supported this course of action.

Mr. Speaker, your reference committee recommends that the Committee on Discipline be abolished.

14. Supplemental Report B, Board of Trustees and Councilors, Recommendations dealing with administrative councils
Resolution 77-20: Creation of an Additional Administrative Council (Delegates' Packets)
Subject: Creation of an Additional Administrative Council
Introduced by: Henry H. Fetterman, M.D., Lehigh County
Author: Henry H. Fetterman, M.D., Lehigh County

WHEREAS, In recent years, socio-economic issues have arisen in increasing numbers; and

WHEREAS, These issues have been directed to the Council on Medical Service to the point where that body's accountabilities have become overwhelming; therefore be it

RESOLVED, That an additional council be created to assume certain responsibilities of the Council on Medical Service as determined appropriate by the Board of Trustees and Councilors. *(Financial Note: Estimated $60,000.)* Requires two-thirds vote.

Because of the similar nature of the above items, the reference committee considered them at the same time. The Committee reviewed the recommendation of the Board of Trustees and Councilors. The Board's recommendation, if adopted, would delete the present specific wording in the Bylaws in relation to the administrative councils, thereby allowing flexibility as to the number of councils and each council's accountabilities. Testimony heard at the reference committee hearing was in support of the Board's recommendation.

Mr. Speaker, your reference committee recommends that the present language in Chapter XIV, Section 4 of the PMS Bylaws dealing with the names and accountabilities of administrative councils be deleted.

Mr. Speaker, your reference committee further recommends that Resolution 77-20 be referred to the Board of Trustees and Councilors for consideration.

15. Supplemental Report B, Board of Trustees and Councilors, Recommendation concerning name change for Council on Governmental Relations; recommendation concerning name change for Council on Medical Service.

In view of the above recommendation, the reference committee feels that these name changes for Councils should be considered by the Board of Trustees and Councilors.

Mr. Speaker, your reference committee recommends that the section of Supplemental Report B of the Board of Trustees and Councilors dealing with name changes for councils be referred to the Board for consideration and implementation.

Mr. Speaker, your reference committee recommends that Supplemental Report B of the Board of Trustees and Councilors be filed.

16. Supplemental Report F, Board of Trustees and Councilors (distributed)

The reference committee reviewed those sections of Supplemental Report F which had not already been considered or referred to another reference committee. Special note was given to the section on countersuits.

Mr. Speaker, your reference committee recommends that Supplemental Report F of the Board of Trustees and Councilors be filed.

17. Resolution 77-40 (distributed)
Subject: Commendation of Pennsylvania Insurance Commissioner
Introduced by: William J. Pherson, M.D., Delegate, Butler County Medical Society
Author: William J. Pherson, M.D., Delegate, Butler County Medical Society

RESOLVED, The author wishes to propose that the House of Delegates commend the present Pennsylvania Insurance Commissioner for his diligence in attending to the insurance needs as the needs of the citizens; and be it further

RESOLVED, He has indeed demonstrated that he is the "servant of the people" as his diligence has, I believe, resulted in lower medical costs to the citizens of Pennsylvania.
(Financial Note: No financial impact.)
Requires two-thirds vote.

The reference committee agrees with the intent of Resolution 77-40, but feels that the intent might better be expressed by the following substitute resolution:

"WHEREAS, The present Pennsylvania Insurance Commissioner has indeed demonstrated that he is the "servant of the people" as his diligence has resulted in lower medical costs to the citizens of Pennsylvania; therefore be it

RESOLVED, That the House of Delegates commend the Pennsylvania Insurance Commissioner for his diligence in attending to the insurance needs of the citizens of the Commonwealth of Pennsylvania."

Mr. Speaker, your reference committee recommends adoption of the above substitute resolution.

18. Address of William J. Kelly, M.D., President (appears elsewhere in this issue)

Your reference committee has reviewed the comprehensive address of the President, Dr. Kelly. We feel he has clearly summarized the accomplishments of the past year and the challenges that lie before us. We commend him for his dedication and service to his colleagues and for the diligence and vigor in which he has approached the problems facing our profession over the past year. Your reference committee considered the following recommendation in his address:

"I am therefore recommending legislation which would give the State Board of Medical Education and Licensure a reasonable amount of time in which to adjudicate complaints against doctors, perhaps 60 days with an extension of 30 days.

"But after that, the reporting group would have the right to go to Commonwealth Court and to call for a show cause hearing why the license of the doctor under question should not be at least suspended until such time as his case is adjudicated by the State Board of Medical Education and Licensure."

Mr. Speaker, your reference committee recommends that the above recommendation of President William J. Kelly,

M.D., be referred to the Council on Governmental Relations for consideration and possible implementation.

Mr. Speaker, your reference committee recommends that the remaining sections of the address of William J. Kelly, M.D., President, be filed.

19. Address of John V. Blady, M.D., President Elect (appears elsewhere in this issue)

Your reference committee has reviewed the comprehensive address of the President Elect, Dr. Blady. The reference committee commends Dr. Blady for his thought-provoking address and considered the following actions from his address:

"I recommend that the specialty societies, particularly at the state level, refrain from pursuing their own economic and legislative programs and instead, work with the Pennsylvania Medical Society in the development of these pursuits.

"I further recommend that specialty societies with economic and legislative problems bring them to the Pennsylvania Medical Society first to seek the support of the entire house of medicine for their cause, rather than start actions which cause greater involvement then they foresaw and frequently produce irreparable damage."

(Secretary's Note: Dr. Blady then made the following amendments to the above two recommendations: deleted the first recommendation and proposed the following substitute recommendation for the second recommendation: "I recommend that specialty societies with economic and legislative problems bring them to the Pennsylvania Medical Society to seek the support of the entire house of medicine for their cause prior to starting independent actions which cause greater involvement than they foresaw and may produce difficulties in pursuing these activities.")

Mr. Speaker, your reference committee recommends approval of the above recommendations as amended by President Elect John V. Blady, M.D.

Mr. Speaker, your reference committee recommends that the additional recommendations of President Elect John V. Blady, M.D., be referred to the Board of Trustees and Councilors for consideration.

Mr. Speaker, your reference committee recommends that the remaining sections of the address of President Elect John V. Blady, M.D., be filed.

DISTINGUISHED GUESTS

The following distinguished guests were introduced to the House: Dr. Robinson G. Fry, president, Pennsylvania Osteopathic Medical Association; Mr. Irwin Reich, president, Pennsylvania Pharmaceutical Association; Carl E. Glock, Jr., Esquire, president, Pennsylvania Bar Association; Dr. John J. Coury, trustee, AMA Board of Trustees; Dr. John J. Egan, president elect, Medical Society of Delaware; and Dr. Raymond J. Saloom, past president, Pennsylvania Osteopathic Medical Association.

THE HOUSE AS A REFERENCE COMMITTEE OF THE WHOLE

A motion was made from the floor to accept as the business of the House Resolution 77-45. This motion passed.

Resolution 77-45

(Referred to the House as a Reference Committee of the Whole)
Subject: HEW Rules and Regulations—National Guidelines for Health Planning
Introduced by: William Long, M.D., Delegate, Clinton County
Author: Robert Beckley, M.D.

WHEREAS, The National Health Planning Resources and Development Act of 1974 (P.L. 93-641) intended that guidelines concerning national health planning policy be developed and applied at the local level; and

WHEREAS, The U.S. Department of HEW proposed regulations entitled "National Guidelines for Health Planning" published in the September 23, 1977 issue of the "Federal Register"; and

WHEREAS, The proposed HEW regulations are arbitrary, rigid, and lacking input from both providers and consumers at the local level which will preclude reasonable and effective implementation of the intent of the Law; therefore be it

RESOLVED, That the Pennsylvania Medical Society's House of Delegates express its opposition to administrative regulations pre-empting the local organizations' determinations, and that copies of this expression also be submitted to our congressional delegation; and be it further

RESOLVED, That the Pennsylvania Medical Society solicit help of the American Medical Association in taking action to oppose previous administrative limitation of legislative local responsibilities for "medical care."

(Financial Note: No financial impact.)

Requires three-fourths vote.

A motion was made from the floor to amend the final resolved in this resolution to state: "RESOLVED, That the Pennsylvania Medical Society solicit help of the American Medical Association in taking action to oppose and/or prevent administrative limitation of legislated local responsibility." This motion passed.

REFERENCE COMMITTEE MEDICAL SERVICE "B"

Roderick R. McLoed, M.D. (Armstrong) Chairman, presented the following report of the Committee:

Mr. Speaker, the Reference Committee on Medical Service "B" has considered all of the items listed in the Index.

1. 1977 Annual Report, Board of Directors, Pennsylvania Medical Care Foundation (mailed to delegates prior to meeting), Address of Foundation President (distributed to House); the section of Supplemental Report F of PMS Board of Trustees and Councilors re: Pennsylvania Medical Care Foundation (distributed to House)

The reference committee heard considerable testimony regarding the recommendation contained on page 2 of the Foundation's annual report and the recommendation of the PMS Board of Trustees contained on page 3 of Supplemental Report F. A member of the PMS Board explained the Board's action regarding a phasing out and transfer of Foundation activities during 1978. There was no testimony presented from others attending the hearing in support of the PMS Board. However, there was considerable testimony supporting the continuation of the Foundation in light of the Foundation's past performance and the need to address the many issues presently under consideration by the Foundation. It was pointed out that the Foundation is the best qualified organization in the state to study the need for and development of alternative health care financing and delivery systems which could afford the highest quality of medical care to citizens of Pennsylvania and be mutually acceptable to both patients and physicians.

Mr. Speaker, your reference committee recommends that the House of Delegates approve the Foundation's plans and objectives for 1977-78 and the recommendations of the Foundation's Board of Directors on page 2 of its annual report.

Your reference committee also recommends that the Foundation's primary function during 1978 should be a study of alternative health care financing and delivery systems to determine the need to plan for the development of a physician operated program with a report of its findings to be presented at the 1978 meeting of the House of Delegates.

A motion was made from the floor to reconsider the first recommendation concerning the Foundation's plans and objectives for 1977-78. This motion was defeated.

Your reference committee further recommends that the House of Delegates authorize the Pennsylvania Medical Society Board of Trustees and Councilors to allocate the funds

necessary to carry out the Foundation's plans and objectives not otherwise supported by other sources of funding.

A motion was made from the floor to amend this recommendation by saying that a maximum of $75,000 be allocated to the Pennsylvania Medical Care Foundation with no restriction as to use. This amendment was rejected. The original recommendation of the reference committee was adopted.

Mr. Speaker, your reference committee recommends that the remainder of the Foundation's annual report be filed.

2. Reports of Officers - Trustees and Councilors re: Confidentiality and Control of Medical Data (Official Reports Book, page 22) and Supplemental Report E of PMS Board of Trustees and Councilors - Implementation of 1976 House of Delegates Action 10.05 re: PMS Medical Data System (Delegates' Packet)

Your reference committee believes that the actions and activities of the PMS Board of Trustees reaffirm Society policy on confidentiality and control of medical data and represents the satisfactory implementation of House actions.

Mr. Speaker, your reference committee recommends approval of the Board of Trustees policy on confidentiality and control of medical data and its implementation of Action 10.05 of the 1976 House of Delegates.

3. Resolution 77-5: AMA Assistance - Corporate Liability Insurance For PSROs (Official Reports Book, page 89)

Subject: AMA Assistance - Corporate Liability Insurance For PSROs

Introduced by: Donald C. Brown, M.D., Westmoreland County

Author: Donald C. Brown, M.D., Westmoreland County

WHEREAS, Local professionals standards review organizations must have corporate liability insurance; and

WHEREAS, This corporate liability insurance is currently offered only through the American Association of PSROs, and membership in that organization is required to obtain this insurance; and

WHEREAS, Since the inception of this group coverage, no claims have been made, indicating the risk is minimal; and

WHEREAS, Since it is evident by the number of PSRO areas that are currently funded that physicians have voluntarily assumed PSRO responsibility on the national scale, another PSRO insurance group is now financially feasible because of the additional PSROs needing this coverage; and

WHEREAS, There is not now a competitive market for PSRO corporate liability coverage; and

WHEREAS, The American Medical Association House of Delegates has indicated their desire to become involved with PSROs; therefore be it

RESOLVED, That the Pennsylvania Medical Society House of Delegates propose to the American Medical Association House of Delegates via this resolution, that in the interest of the physicians involved in PSROs, the American Medical Association assist PSROs in locating corporate liability insurance which is not limited or restricted by membership requirements or requirements other than being a qualified PSRO, and that the AMA secure or develop for PSROs a suitable group participation policy as an alternate to the AAPSRO offering; and be it further

RESOLVED, That the Pennsylvania Medical Society refer this matter to the American Medical Association House of Delegates for their consideration and early action.

(Financial Note: No financial impact.)

Testimony supported the intent of this resolution. The author agreed to a substitute resolution.

Mr. Speaker, your reference committee recommends approval of the following substitute resolution:

RESOLVED, That the Pennsylvania Medical Society request the American Medical Association to assist PSROs in securing corporate liability insurance which is not limited or restricted by membership requirements or requirements other than that of being a qualified PSRO.

4. Reports of Officers - Trustees and Councilors re: Health Service Areas and Health Systems Agencies (Official Reports Book, page 27)

Mr. Speaker, your reference committee recommends that this report be filed.

5. Pennsylvania Blue Shield 1977 Report to PMS House of Delegates (Delegates' Packet)

Testimony was presented reflecting concern over certain policies and procedures established by Blue Shield as reflected in the report. The reference committee believes the Pennsylvania Medical Society Council on Medical Service should continue to monitor the Blue Shield activities described in the report.

Mr. Speaker, your reference committee recommends that the Pennsylvania Blue Shield 1977 report to the House of Delegates be referred to the Pennsylvania Medical Society's Council on Medical Service and further suggests that Blue Shield distribute future reports to delegates prior to the meeting of the House of Delegates.

6. Supplemental Report C of PMS Board of Trustees and Councilors - Relationship—PMS and Pennsylvania Blue Shield (Delegates' Packet)

While Blue Shield representatives testified indicating their desire for continued physician involvement in the Blue Shield corporate structure, there was no other testimony in opposition to the recommendations of the PMS Board of Trustees and Councilors as contained on page 2 of Supplemental Report C.

Mr. Speaker, your reference committee recommends that it be the policy of the Pennsylvania Medical Society that in the future, no one in an elected PMS leadership position, i.e., trustee and councilor and officers, should serve on the Blue Shield Board of Directors.

Your reference committee further recommends that the PMS Board of Trustees and Councilors should discontinue making appointments of the members-at-large to the corporate membership of Pennsylvania Blue Shield.

Your reference committee also recommends that the Pennsylvania Medical Society should encourage Blue Shield to develop an alternative method of soliciting nominees for election to the Blue Shield corporate membership other than direct solicitation of county medical societies.

A motion was made from the floor to amend this recommendation. This motion passed. (*Secretary's Note:* This recommendation now reads: "Your reference committee also recommends that the Pennsylvania Medical Society should encourage Blue Shield to develop an alternative method of soliciting nominees for election to Blue Shield corporate membership in addition to direct solicitation of county medical societies.")

7. Resolution 77-4: Blue Shield Physician Payment Schedules (Official Reports Book, page 88)

Subject: Blue Shield Physician Payment Schedules

Introduced by: Edward J. Resnick, M.D., Secretary, on behalf of the Philadelphia County Medical Society

Author: David S. Cristol, M.D., on behalf of the Philadelphia County Medical Society

WHEREAS, Pennsylvania Blue Shield schedules of reimbursement for physicians under Prevailing Fee Program and the Medicare Program are based on criteria which are unduly complex and which result in inequitable payment to physicians on the basis of geographic location; and

WHEREAS, The basis of payment to physicians has remained relatively unchanged over a long period of time; and

WHEREAS, In many instances, older and established physicians are not allowed as much compensation as younger physicians in the same geographic area; therefore be it

RESOLVED, That the Pennsylvania Medical Society urge Pennsylvania Blue Shield to conduct a study of these inequities in payments to physicians and to develop and adopt criteria for payment for physician services which will establish payment schedules on an updated inequitable basis.
(Financial Note: No financial impact.)

Resolution 77-8: Pennsylvania Blue Shield and Update (Official Reports Book, page 89)
Subject: Pennsylvania Blue Shield and Update
Introduced by: Henry H. Fetterman, M.D., Lehigh County
Author: Henry H. Fetterman, M.D.

WHEREAS, Reasonable, customary, and usual fees are determined by charges; and

WHEREAS, Area inequities have arisen by the lag in updates, many times taking two years; therefore be it

RESOLVED, That Blue Shield and other insurance carriers be encouraged to find a new mechanism to provide a method of establishing concurrent and ongoing fee updates; and be it further

RESOLVED, That this resolution be submitted to the American Medical Association.
(Financial Note: No financial impact.)

The reference committee heard considerable testimony regarding the problems confronting Blue Shield and physicians related to equitable payment and timely updates of physician profiles. Your reference committee is aware that these problems have been discussed in prior meetings of the House of Delegates and have been under constant consideration by the PMS Council on Medical Service. The reference committee concluded that additional effort must be expended over the next year to find solutions to the continuing problems identified in Resolution 77-4 and 77-8.

Mr. Speaker, your reference committee recommends that Resolution 77-4 and 77-8 be referred to the PMS Council on Medical Service for study and report back to the 1978 House of Delegates.

8. Resolution 77-6: Specialty Societies - Pennsylvania Blue Shield Consult Specialty Societies' Advisory Committees before Declaring Operating and Other Procedures Obsolete (Official Reports Book, page 89)
Subject: Specialty Societies - Pennsylvania Blue Shield Consult Specialty Societies' Advisory Committees before Declaring Operating Procedures Obsolete
Introduced by: Leopold S. Loewenberg, M.D., Specialty Delegate from the Pennsylvania Section of the American College of Obstetricians and Gynecologists
Author: Leopold S. Loewenberg, M.D.

WHEREAS, Pennsylvania Blue Shield has declared certain operative procedures not coverable by virtue of Blue Shield's opinion that these procedures are obsolete; and

WHEREAS, Pennsylvania Blue Shield has consulted their own advisors pursuant to their decision; and

WHEREAS, The various state specialty societies have not been consulted on these matters; therefore be it

RESOLVED, That Pennsylvania Blue Shield be encouraged, in the interest of improved public relations with the specialty societies, to consult the advisory committee of each specialty society before final disposition is made to declare operative procedures obsolete and unreimbursable.
(Financial Note: No financial impact.)

Testimony presented indicated inadequate communications regarding the activities of Blue Shield in obtaining the advice of the PMS Council on Medical Service regarding obsolete, operative, and medical procedures. The reference committee believes that the existing mechanism for the Society to provide advice to Blue Shield must be reinforced.

Mr. Speaker, your reference committee therefore recommends approval of the following substitute resolution:

"RESOLVED, That Pennsylvania Blue Shield be encouraged to consult with the PMS Council on Medical Service and its specialty advisory committees in making decisions regarding the obsolescence of operative or medical procedures as it relates to Blue Shield reimbursement for such products."

9. Resolution 77-7: Specialty Societies - Pennsylvania Blue Shield Appointments of Advisors (Official Reports Book, page 89)
Subject: Specialty Societies - Pennsylvania Blue Shield Appointments of Advisors
Introduced by: Leopold S. Loewenberg, M.D., Specialty Delegate from the Pennsylvania Section of the American College of Obstetricians and Gynecologists
Author: Leopold S. Loewenberg, M.D.

WHEREAS, Pennsylvania Blue Shield is concerned with the standards of medical practice and appoints or hires advisors for this purpose; and

WHEREAS, Each specialty society can best know the qualifications of these individuals; therefore be it

RESOLVED, That Pennsylvania Blue Shield be encouraged to contact each specialty society for a list of competent individuals from which to choose advisors; and be it further

RESOLVED, That Pennsylvania Blue Shield be encouraged to limit the term of appointment, fully understanding that reappointment can be done if the specialty society feels that that particular individual maintains his expertise in his specialty.
(Financial Note: No financial impact.)

It is the feeling of the reference committee that it is not the prerogative of the Pennsylvania Medical Society to dictate to Blue Shield whom they should hire or retain as medical advisors. However, your reference committee believes that Blue Shield should make every effort to select qualified individuals for such positions.

Mr. Speaker, your reference committee recommends approval of the following substitute resolution:

"RESOLVED, That the Pennsylvania Medical Society urge Blue Shield to select practicing physicians qualified in their specialty to serve as Blue Shield medical advisors."

10. Resolution 77-18: Interference with Professional Judgment of Physician (Delegates' Packet)
Subject: Interference with Professional Judgment of Physician
Introduced by: Milton M. Perloff, M.D., Philadelphia County Medical Society
Author: Milton M. Perloff, M.D., Philadelphia County Medical Society

WHEREAS, Physicians have an individual responsibility to treat patients in terms of the disease or disability of each patient, taking into consideration a wide spectrum of factors involved in each patient; and

WHEREAS, Different patients require different treatment or degrees thereof; and

WHEREAS, Physicians will not be able to provide optimal care to their patients if they are limited in the exercise of their best judgment by being prohibited from using certain modalities of treatment, or are prevented from charging for such services, in part or in toto; therefore be it

RESOLVED, That the Pennsylvania Medical Society adopt a policy of opposition to Pennsylvania Blue Shield, or any other health insurance carrier, establishing rules or regulations which state that the use of selective procedures is unnecessary, or prohibited, in part or in toto; and be it further

RESOLVED, That the Pennsylvania Medical Society oppose any agreements such as those of Blue Shield participating physicians which would deny a physician the right to bill a patient for care not provided by the insurance agreement.
(Financial Note: No financial impact.) Requires two-thirds vote.

Testimony presented indicated that the second resolved of Resolution 77-18, as written, is inaccurate since Blue Shield policy does

allow a physician to bill a patient for care provided which is not covered by the Blue Shield agreement.

Mr. Speaker, your reference committee recommends approval of the following substitute resolution:

"RESOLVED, That it is the position of the Pennsylvania Medical Society that third party health insurance carriers should not establish rules and regulations which arbitrarily identify selected procedures as unnecessary without appropriate professional medical review."

11. Resolution 77-31: Blue Shield's Vision and Hearing Care Program for United Auto Workers (Delegates' Packet)

Subject: Blue Shield's Vision and Hearing Care Program for United Auto Workers

Introduced by: David A. Smith, M.D., Secretary/Treasurer, on behalf of the Dauphin County Medical Society

Author: Ronald M. Grossman, M.D.

RESOLVED, That the recently negotiated contract between the United Auto Workers and Blue Shield be soundly condemned by the PMS for its provision concerning vision and hearing care, wherein the policy of non-payment for services provided by non-participating physicians in Blue Shield is contained.

Said policy is felt to essentially restrict the patient's freedom of choice of physician and is to be condemned and legal avenues should be immediately explored to combat this action.

(Financial Note: No financial impact.) Requires two-thirds vote.

A motion was made from the floor to amend Resolution 77-31 as follows,

"RESOLVED, That the recently negotiated contract between the United Auto Workers and Blue Shield be soundly condemned by the PMS for its provision concerning vision and hearing care, wherein the policy of non-payment for services provided by non-participating physicians in Blue Shield is contained. Said policy is felt to essentially restrict the patient's freedom of choice of physician and is to be condemned."

This amendment was rejected.

Mr. Speaker, your reference committee recommends the adoption of the following substitute resolution:

"RESOLVED, That the Pennsylvania Medical Society inform Blue Shield that its decision to participate in the United Auto Workers vision and hearing care program represents an action which will be destructive to the maintenance of a physician's participatory health insurance plan."

Resolution 77-41: Blue Shield's Vision and Hearing Care Program for United Auto Workers (distributed to House)

Subject: Blue Shield's Vision and Hearing Care Program for United Auto Workers

Introduced by: Paul A. Cox, M.D., Specialty Delegate from the Pennsylvania Academy of Ophthalmology and Otolaryngology

Author: Paul A. Cox, M.D.

WHEREAS, Pennsylvania Blue Shield has agreed to provide glasses to auto workers and to pay participating physicians 80 percent of their usual and customary fee, and to pay the subscribers who go to a non-participating physician 60 percent of his usual and customary fee; and

WHEREAS, Pennsylvania Blue Shield has agreed to provide hearing evaluations to auto workers and to pay the participating physician his usual and customary fee up to the sum of $40 and will pay nothing to the subscribers of a non-participating physician; and

WHEREAS, This is a form of coercion in attempting to force non-participating physicians to join the ranks of Blue Shield; and

WHEREAS, If Blue Shield is allowed to pursue these coercive tactics in the fields of ophthalmology and otolaryngology, they may decide to use the same discriminatory practices in all fields of medicine; therefore be it

RESOLVED, That the Pennsylvania Medical Society is very much opposed to these tactics; and be it further

RESOLVED, That the Pennsylvania Medical Society will oppose these practices of discrimination by whatever means it finds to be necessary.

(Financial Note: No financial impact.) Requires two-thirds vote.

(Secretary's Note: Resolution 77-41 was adopted.)

12. Resolution 77-38: Criteria for Need of Computerized Axial Tomography Units (distributed to House)

Subject: Criteria for Need of Computerized Axial Tomography Units

Introduced by: Aureliano Rivas-Flores, Jr., M.D., Delegate, Montgomery County Medical Society

Author: Aureliano Rivas-Flores, Jr., M.D., Delegate, Montgomery County Medical Society

WHEREAS, Computerized Axial Tomography is a proven, desirable, technological, diagnostic device which provides a faster, more accurate, safer diagnosis; and

WHEREAS, Computerized Axial Tomography is cost effective because it shortens the length of stay in hospital needed to arrive at a definitive diagnosis; and

WHEREAS, The present HSA system of approval for the establishment of a CAT in a given hospital is based (1) on criteria which are considered by many to be very restrictive, (2) penalizes smaller institutions in favor of large, established medical centers and leads to an increasing maldistribution of physicians and medical service delivery, (3) may doom the development of medical centers in non-developed areas; therefore be it

RESOLVED, That the Pennsylvania Medical Society take an active and forceful stand in the subject of CAT by creating an agency that will study and become knowledgeable in all its aspects, to include the present HSA criteria, which appear to be arbitrary. This PMS body can be used for guidance, arbitration, and information to the Society, HSA, and the community in general.

(Financial Note: No financial impact.) Requires two-thirds vote.

Testimony presented supported the intent of this resolution.

Mr. Speaker, your reference committee recommends that Resolution 77-38 be referred to the Commission on Health Planning of the PMS Council on Medical Service.

13. Resolution 77-39: Increased Paperwork Requirements by the Department of Public Welfare (distributed to House)

Subject: Increased Paperwork Requirements by the Department of Public Welfare

Introduced by: Joseph M. Sienkiewicz, M.D., on behalf of the Northumberland County Medical Society

Author: Joseph M. Sienkiewicz, M.D., President, Northumberland County Medical Society

WHEREAS, The volume of paperwork already required of practicing physicians and the amount of time and money needed to complete the paperwork is already burdensome; and

WHEREAS, The Pennsylvania Department of Public Welfare proposes to increase that burden with its new regulations that demand that one patient form be completed per patient visit; and

WHEREAS, The Pennsylvania Department of Public Welfare does not intend to offer additional compensation for this work; therefore be it

RESOLVED, That the House of Delegates oppose any such continued burden by urging each member of the Pennsylvania Medical Society to participate in a paper strike and refuse to complete any paperwork required by the Department of Public Welfare until this regulation is rescinded.

(Financial Note: No financial impact.) Requires two-thirds vote.

Those testifying in the reference committee were highly sympathetic with the intent of this resolution, but at the same time, questioned whether the resolved would provide an effective solution to a very real problem. The reference committee is aware that the PMS Council on Medical Service has been struggling with this

and similar problems over the past several years and will continue its efforts.

Mr. Speaker, your reference committee recommends rejection of Resolution 77-39.

ANNUAL MEETING PENNSYLVANIA MEDICAL CARE FOUNDATION

As in past years, the Annual Meeting of the Pennsylvania Medical Care Foundation was held during the 1977 House of Delegates meeting, and proceeded as follows:

"The chair believes it wise to take a minute to be certain that all members of the House understand how we will consider the next order of business. We wish to convene the annual meeting of the administrative members of the Pennsylvania Medical Care Foundation.

"According to the Foundation's Bylaws, 'administrative members shall consist of those persons who are duly qualified and elected delegates to the House of Delegates of the Pennsylvania Medical Society.' The Bylaws further state, 'The acceptance of election as a delegate to the House of Delegates of the Pennsylvania Medical Society by an eligible physician shall be determined to be acceptance of administrative membership in this corporation and an intention to be bound by the Articles of Incorporation and Bylaws of the corporation unless the delegate otherwise notifies the secretary of the corporation prior to the annual meeting.'

"In other words, the voting members of the House are also the administrative members of the Foundation.

"At this time, the chair will entertain a motion to recess the meeting of the PMS House of Delegates and to convene the administrative members of the Pennsylvania Medical Care Foundation in the annual meeting of the Foundation.

"The chair recognizes the President of the Pennsylvania Medical Care Foundation, Dr. Sidney Krasnoff. Dr. Krasnoff. . ."

"Thank you, Ernie. While it's true that we are sitting now as the administrative members of the Pennsylvania Medical Care Foundation, I am sure that all of us want to expedite the business of the Foundation as quickly as possible. I believe this can best be achieved if we permit an experienced hand to guide us from the speaker's rostrum. For that reason, I would respectfully ask the permission of the administrative members to have Dr. Witt serve as acting speaker of the Foundation so that he may use his skill in parliamentary matters . . . hearing no objections, Dr. Witt, I would ask you to come back and take over."

"Thank you, Sid. The principle item of business this year for the administrative members of the Foundation is the annual report of the Foundation, which contains several recommendations referred to the Reference Committee on Medical Service "B".

"The other item of business this year for the administrative members of the Foundation is the election of six directors - the Board of the Directors of the Foundation presents the following nominees for the vacancies. The Foundation's Bylaws allow for additional nominations to be made from the floor by any administrative member for all vacancies at the time of elections.

Vacancy	*Nominee*	*County*	*Term*
1	Joseph N. Demko, M.D.	Lackawanna	3 year expires 10/80
2	Robert M. Jaeger, M.D.	Lehigh	3 year expires 10/80
3	John W. Lawrence, M.D.	Delaware	3 year expires 10/80
4	Matthew Marshall, Jr., M.D.	Allegheny	3 year expires 10/80
5	Joseph E. Green, III, M.D.	Cumberland	3 year expires 10/80
6	Raymond J. Saloom, D.O.	Butler	3 year expires 10/80

"In the event there is a contest for one of the Foundation slots, the contest will be added to the PMS ballot and delegates will cast their votes tomorrow morning."

(Secretary's Note: There were no nominations from the floor and the nominees listed above were elected.)

"Are there any further actions or comments concerning the Foundation's annual report? If not, the chair will entertain a motion to file the report as presented."

"Is there any further Foundation business? If not, the chair will entertain a motion to adjourn the meeting of the Foundation and reconvene the PMS House."

SPECIAL REPORT REFERENCE COMMITTEE CONSTITUTION AND BYLAWS

A special report of the Reference Committee on Constitution and Bylaws was presented by Betty L. Cottle, M.D. (Blair) Chairman, as follows:

Mr. Speaker, and members of the House of Delegates, the Reference Committee on Constitution and Bylaws has considered the material listed in the Index and presents the following report.

1. Society Restructure (Report of Reference Committee on Report of Officers, distributed)

Administrative structural changes have been recommended and adopted by the House of Delegates. The reference committee has studied the portions of the Bylaws affected by these changes and determined language changes to amend appropriately Chapter XIV of the Bylaws.

Mr. Speaker, we recommend approval of the Bylaws change which allows for flexibility in structuring of administrative councils under the determination of the Board of Trustees and Councilors, subject to review by the House of Delegates. Three-fourths vote required.

(Secretary's Note: This special report was considered during the second session of the House in order to provide sufficient "lay-over time" for any additional Bylaw changes mandated by the House of Delegates. Chapter XVII of the Bylaws requires that all amendments voted on must lie over one day after being received as business of the House.)

NOMINATIONS AND ELECTIONS

Nominations and elections were held Wednesday afternoon, October 26, 1977. Voting for those offices contested was held Thursday morning, October 27. The following officers were elected:

President: John V. Blady, M.D. (Philadelphia) acceded to the office of president

President Elect: John B. Lovette, M.D. (Cambria) acceded to the office of president elect

Vice President: Matthew Marshall, Jr., M.D. (Allegheny)

Secretary: G. Winfield Yarnall, M.D. (Dauphin)

Speaker: D. Ernest Witt, M.D. (Columbia)

Vice Speaker: Donald E. Harrop, M.D. (Chester)

The following Trustees and Councilors were elected:

Seventh District: Kenneth L. Cooper, M.D. (Lycoming)

Tenth District: David W. Clare, M.D. (Allegheny)

Twelfth District: Gerald L. Andriole, M.D. (Luzerne)

Two members were elected to serve on the Committee to Nominate Delegates and Alternates to the AMA. They are: Samuel S. Faris, M.D. (Montgomery) and Charles R. Shuman, M.D. (Philadelphia). Both members were elected to serve full three-year terms on the committee.

Samuel F. Cohen, M.D. (Montgomery) was elected to a three-year term on the Judicial Council.

The following district censors were elected for one year terms: *Adams,* W. North Sterrett; *Allegheny,* William D. Stewart; *Armstrong,* Donald Minteer; *Beaver,* John G. Hallisey; *Bedford,* Robin G. Torres; *Berks,* Brian A. Wummer; *Blair,* John W. Hurst;

Bradford, Arthur B. King; *Bucks,* Stanley F. Peters; *Butler,* Robert C. McCorry; *Cambria,* Warren F. White; *Carbon,* _____; *Centre,* H. Thompson Dale; *Chester,* Michael B. Dooley; *Clarion,* Charles C. Huston; *Clearfield,* Fred Pease; *Clinton,* George J. Treires; *Columbia,* C. Perry Cleaver; *Crawford,* David D. Kirkpatrick, Jr.; *Cumberland,* Hans S. Roe; *Dauphin,* Robert P. Dutlinger; *Delaware,* Arthur S. Reynolds; *Elk-Cameron,* Robert J. Dickenson; *Erie,* Robert L. Loeb; *Fayette,* Veronica Binns; *Franklin,* Albert W. Freeman; *Greene,* _____; *Huntingdon,* _____; *Indiana,* Richard N. Freda; *Jefferson,* Nicholas F. Lorenzo; *Lackawanna,* Norman S. Berger; *Lancaster,* William C. Phippen; *Lawrence,* Gerald H. Weiner; *Lebanon,* John D. Walmer; *Lehigh,* Robert J. Beitel, Jr.; *Luzerne,* _____; *Lycoming,* Franklin G. Wade; *McKean,* Bruno P. Sicher; *Mercer,* Anderson W. Donan; *Mifflin-Juniata,* Donald E. Basom; *Monroe,* _____; *Montgomery,* _____; *Montour,* William O. Curry, Jr.; *Northampton,* Walter J. Filipek; *Northumberland,* Nicholas Spock; *Perry,* James O. Rumbaugh, Jr.; *Philadelphia,* Charles M. Thompson; *Potter,* Francisco B. Villa; *Schuylkill,* Gabriel M. Lizak; *Somerset,* Alexander Solosko; *Susquehanna,* _____; *Tioga,* William A. Coolidge; *Union,* Joseph Weightman; *Venango,* Kenneth H. Heasley; *Warren,* William S. Walters; *Washington,* John C. McGinnis; *Wayne-Pike,* _____; *Westmoreland,* Leslie S. Pierce; *Wyoming,* John S. Rinehimer, Jr.; *York,* Donald R. Gross.

(Secretary's Note: The Board of Trustees has the power to appoint district censors to fill vacancies.)

REPORT OF THE COMMITTEE TO NOMINATE DELEGATES AND ALTERNATES TO THE AMA

The vice speaker announced the elections for delegates and alternates to the American Medical Association. The nominations of the Committee to Nominate Delegates and Alternates to the American Medical Association were published on page 1 of the Official Reports Book. Elected to two year terms beginning January 1, 1978, and expiring December 31, 1979, were:

Henry H. Fetterman, M.D. (Lehigh)
John B. Lovette, M.D. (Cambria)
Matthew Marshall, Jr., M.D. (Allegheny)
Robert N. Moyers, M.D. (Crawford)
R. Robert Tyson, M.D. (Philadelphia)

Five alternate delegates were elected for two year terms beginning January 1, 1978, and expiring December 31, 1979:

Robert J. Carroll, M.D. (Allegheny)
Lawrence D. Ellis, M.D. (Allegheny)
George R. Fisher, M.D. (Philadelphia)
Wayne W. Helmick, M.D. (Beaver)
David J. Keck, M.D. (Erie)

(Secretary's Note: Due to Dr. R. Robert Tyson's one year unexpired term as an alternate delegate to the AMA, nominations will be made Thursday morning for that vacancy and voting held immediately. Following the fixing of the annual assessment, the results of that election will be announced.)

REFERENCE COMMITTEE PROFESSIONAL RELATIONS AND SERVICES

Arthur J. Patterson, M.D. (Greene), chairman, presented the following report of the committee:

Mr. Speaker, the Reference Committee on Professional Relations and Services has considered all of the items listed in the Index above.

1. Report of the Council on Professional Relations and Services (Official Reports Book, pages 76-82)

The reference committee heard no testimony in opposition to the Council's recommendation to eliminate the delinquent dues provision permanently.

Mr. Speaker, the reference committee recommends that the delinquent dues provision of the Society be eliminated permanently.

The remainder of the Council's annual report is very informative. Upon review, it was found to be detailed and impressive. The reference committee would like to call attention to the Council's effort in the area of membership recruitment and more particularly, in the area of new membership benefits. Along that line, the reference committee should point out the establishment of the Pennsylvania Medical Society Credit Union for members, employees, Medical Society staff and family. All members should review this new benefit and make use of it wherever possible. The reference committee would like to commend the Council and its staff for the past year's activities.

Mr. Speaker, the reference committee recommends that the remainder of the annual report of the Council on Professional Relations and Services be filed.

2. Supplemental Report, Council on Professional Relations and Services (Delegates' Packets) and Supplemental Report F, Board of Trustees (portions re: intern and resident and medical school section, distributed)

Because of the similar nature of the items listed above, the reference committee considered them as one item. The only testimony presented to the reference committee was in favor of the establishment of the Resident Physician Section. The reference committee favors the wording of the resolution contained in Supplemental Report F of the Board of Trustees stating that the Resident Physician Section should be available only to resident physician members of the Pennsylvania Medical Society.

Mr. Speaker, the reference committee recommends approval of the resolution contained in Supplemental Report F of the Board of Trustees.

The only testimony presented to the reference committee was in favor of the establishment of the medical school section.

Mr. Speaker, the reference committee recommends approval of the medical school section as contained in Supplemental Report F of the Board of Trustees.

3. The reference committee has grouped the following items together in a waiver of debate list:

Report, Advisory Committee to the PMS Auxiliary (Official Reports Book, page 53) (File)
Address of the President, PMS Auxiliary (distributed) (File)
Annual Report, Pennsylvania Medical Cooperative (distributed) (File)
Annual Report, Board of Trustees (portion re: Pennsylvania Medical Cooperative, Official Reports Book, page 26) (File)

Mr. Speaker, we recommend that these items be filed.

4. Resolution 77-25: AMA Direct Membership Dues Billing (distributed)

Subject: AMA Direct Membership Dues Billing
Introduced by: Montgomery County Medical Society Delegation
Author: Alan L. Dorian, M.D., Delegate, Montgomery County Medical Society

WHEREAS, The AMA has proposed direct dues billing for AMA members; and

WHEREAS, The PMS and its component county medical societies have together effectively established an efficient dues collection system; and

WHEREAS, The federation concept of national, state, and county societies is enhanced by one billing for all at the county level; therefore be it

RESOLVED, That PMS inform the AMA that PMS and its component county medical societies prefer this proposal be offered to each state on an optional basis.

(Financial Note: No financial impact.) Requires two-thirds vote.

Testimony presented was in favor of preserving the present system of the American Medical Association offering direct mem-



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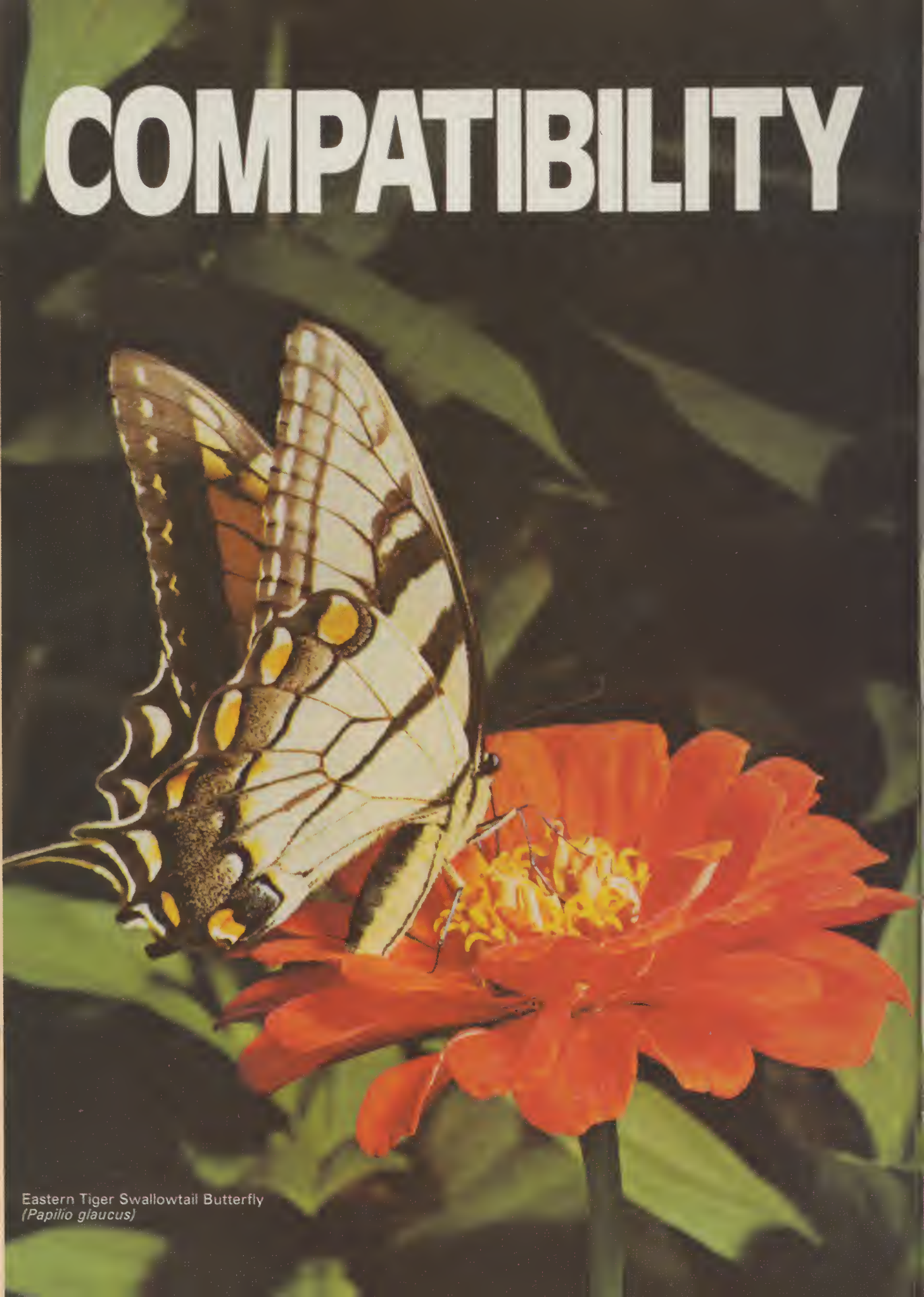
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Vasodilan–compatible with your total regimen for vascular insufficiency

Vasodilan can be a valuable adjunct in planning a total therapeutic program for vascular insufficiency.

***Indications:** Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg. Vasodilan injection, isoxsuprine HCl, 5 mg., per ml.

Dosage and Administration: Oral: 10 to 20 mg., three or four times daily. Intramuscular: 5 to 10 mg. (1 or 2 ml.) two or three times daily. Intramuscular administration may be used initially in severe or acute conditions.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Parenteral administration is not recommended in the presence of hypotension or tachycardia.

Intravenous administration should not be given because of increased likelihood of side effects.

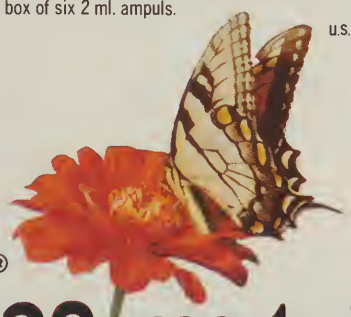
Adverse Reactions: On rare occasions oral administration of the drug has been associated in time with the occurrence of hypotension, tachycardia, nausea, vomiting, dizziness, abdominal distress, and severe rash. If rash appears the drug should be discontinued.

Although available evidence suggests a temporal association of these reactions with isoxsuprine, a causal relationship can be neither confirmed nor refuted.

Administration of single dose of 10 mg. intramuscularly may result in hypotension and tachycardia. These symptoms are more pronounced in higher doses. For these reasons single intramuscular doses exceeding 10 mg. are not recommended. Repeated administration of 5 to 10 mg. intramuscularly at suitable intervals may be employed.

Supplied: Tablets, 10 mg., bottles of 100, 1000, 5000 and Unit Dose; Tablets, 20 mg., bottles of 100, 500, 1000, 5000 and Unit Dose; Injection, 10 mg. per 2 ml. ampul, box of six 2 ml. ampuls.

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Dosage: Initial: Adults: 1-2 capsules or 1-2 tablespoonfuls elixir every 6-8 hours, children 8-12: 1 tablespoonful or one capsule every 6-8 hours and children under 8: 3 to 5 mg theophylline/kg body weight every 6-8 hours. Theophylline dosage may be cautiously increased to 2000 mg/24 hr in adults or 7 mg/kg in children; monitoring of serum theophylline levels at higher dosages is recommended.
Precautions: Do not administer more frequently than every 6 hours, or within 12 hours after rectal dose of any preparation containing theophylline or aminophylline. Do not give other xanthine derivatives concurrently. Use in case of pregnancy only when clearly needed.
Adverse Reactions: Theophylline may exert some stimulating effect on the central nervous system. Its administration may cause local irritation of the gastric mucosa, with possible gastric discomfort, nausea and vomiting. The frequency of adverse reactions is related to the serum theophylline level and are not usually a problem at serum theophylline levels below 20μg/ml.
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bership dues billing on an optional basis. The reference committee recommends the following substitute resolve:

"RESOLVED, That the American Medical Association's direct membership dues billing continue to be offered to state and component medical societies on an optional basis and that the Pennsylvania Medical Society inform the AMA of its position."

Mr. Speaker, the reference committee recommends approval of the substitute resolve.

RECESS

The House recessed at 5:10 p.m. until the opening of the final session at 9:30 a.m., Thursday, October 27.

THIRTIETH STATE DINNER

Prior to the 1977 State Dinner, a reception was held in the Monte Carlo and La Fonda Rooms of the Host Farm Resort Motel. As in past years, this reception was courtesy of the Frank B. Hall & Company of Pennsylvania, Inc. At 8:00 p.m., all those present moved to the Baroque Ballroom where dinner was served.

The invocation was given by Rev. Francis Gilligan, former headmaster at the Malvern Preparatory School, Malvern, and currently involved in parochial duties at St. Rita's Roman Catholic Church.

Introduction of Dignitaries

In order to shorten the official program of State Dinner, Dr. Kelly dispensed with the formal introduction of the head table, guests of the Society, and the past presidents of the Society. Dr. Blady then introduced his guests.

Presentation of Gavel to Immediate Past President of the Pennsylvania Medical Society Auxiliary

Dr. Kelly presented the Past President's Gavel to Mrs. Spencer J. Servoss, immediate past president of the Pennsylvania Medical Society Auxiliary, in recognition of her services as president of the Auxiliary during the year ending with the 1977 Auxiliary House of Delegates.

Presentation of Retiring Trustee Award

Dr. Rowland presented the Retiring Trustee Award to Orlo G. McCoy, M.D., retiring trustee and councilor of the Twelfth Councilor District.

Installation of the President

Dr. George A. Rowland, chairman of the Board of Trustees of the Pennsylvania Medical Society, installed Dr. John V. Blady, Philadelphia County, as the 128th president of the Pennsylvania Medical Society. After taking the oath of office, Dr. Blady delivered brief remarks.

Presentation of Past President's Medallion

Dr. Rowland presented the Past President's Medallion to Dr. William J. Kelly, Allegheny County, in tribute to his great efforts in behalf of the Pennsylvania Medical Society as its 127th president.

Adjournment

The formal portion of the program adjourned at 9:15 p.m. Members and their guests were entertained until 12 p.m. by King Henry and The American Show Band.

Final Session of the House of Delegates October 27, 1977

The final session of the 1977 Annual Session of the House of Delegates was called to order in the Baroque Ballroom of the Host Farm Resort Motel, Lancaster, Thursday, October 27, 1977, at 9:40 a.m.

Dr. Joseph M. Sienkiewicz (Northumberland) reported that a quorum was in attendance.

SPECIAL REPORT REFERENCE COMMITTEE CONSTITUTION AND BYLAWS

The special report of the Reference Committee on Constitution and Bylaws, which was presented at Wednesday's session by Dr. Betty L. Cottle (Blair), Chairman, was presented in order for the House to vote on the Bylaws changes.

Mr. Speaker, we recommend approval of the Bylaws change which allows for flexibility in structuring of administrative councils under the determination of the Board of Trustees and Councilors, subject to review by the House of Delegates. Three-fourths vote required.

(Secretary's Note: A motion was made from the floor to amend the portion on page 3 of the reference committee report which states, "The administrative council shall conduct all of the activities and business of the Society, except as otherwise provided by the Constitution and Bylaws. This Society shall have administrative councils as deemed necessary to carry out the business of the Society. The final determination thereof shall be the responsibility of the Board of Trustees and Councilors, subject to review by the House of Delegates." This amendment was passed. This portion now reads, "This Society shall have administrative councils as deemed necessary to carry out the business of the Society. The administrative councils shall conduct all of the activities and business of the Society, except as otherwise provided by the Constitution and Bylaws. The final determination thereof shall be the responsibility of the Board of Trustees and Councilors, subject to review by the House of Delegates.")

REFERENCE COMMITTEE EDUCATION AND SCIENCE

William J. West, M.D. (Cumberland), Chairman, presented the following report of the Committee:

Mr. Speaker, the Reference Committee on Education and Science has considered all the reports and resolutions listed in the Index.

1. Waiver of debate list

Your reference committee groups the following items together in a waiver of debate list. In each instance, there was little or no testimony heard and your reference committee feels the items are of a non-controversial nature.

Mr. Speaker, we recommend the following actions on each item:

Report of the Ad Hoc Committee on the Impaired Physician (Official Reports Book, page 21) (approve)

Report of the Educational and Scientific Trust (Delegates' Packet) (approve)

2. Report of the Council on Education and Science (Official Reports Book, page 57)

Your reference committee heard no adverse comments about the Council's report; therefore, we can assume that they are doing what is in the best interest of our members. One issue was raised under school health regarding immunization and the use of live vaccine in women of childbearing age.

Mr. Speaker, your reference committee recommends the filing of the report of the Council on Education and Science with the request that the Council continue to study the immunization problem mentioned above.

3. Report of the Committee on Aid to Education (Official Reports Book, page 53)

Your reference committee heard strong support for the contin-

uation of the $8 allocation for support of the Educational Fund. A question was raised as to whether this amount was adequate. As a result of the testimony, your reference committee recommends a review and reassessment of the Society's aid to medical education and that the Committee on Aid to Education explore what new avenues may be available to aid students. Even though your reference committee is opposed to further government control, there must be governmental support toward medical education and we would urge that this Society vigorously pursue increased appropriations for Pennsylvania medical schools.

Mr. Speaker, your reference committee recommends the adoption of this portion of the reference committee report.

4. Resolution 77-21: Use of Anorexiants for Treatment of Obesity (Delegates' Packet)
Subject: Use of Anorexiants for Treatment of Obesity
Introduced by: John S. Parker, M.D., Westmoreland County Medical Society
Author: John S. Parker, M.D., Westmoreland County Medical Society

WHEREAS, Effectively maintained weight reduction is based upon the understanding of good nutrition and an alteration of the underlying psychological or pathological factors that produce excessive caloric intake; and

WHEREAS, Most anorexiants are central nervous system agents whose use is fraught with side effects and worse, psychic and physical dependence, resulting in abuse and even death; and

WHEREAS, Studies have failed to show any precise pharmacologic activity that would justify their name; therefore be it

RESOLVED, That the Pennsylvania Medical Society publicly announce its support for withdrawal of these agents from the market for use in the treatment of obesity.

(Financial Note: No financial impact.) Requires two-thirds vote.

Your reference committee heard extensive testimony on the problems of the treatment of obesity. Your reference committee rejects the resolution because it would be impossible to regulate certain drugs without governmental intervention. The issue of the treatment of obesity goes beyond the use of anorexiants. Our substitute resolution is as follows:

"RESOLVED, That the key to medically safe treatment of obesity continues to center on sound nutrition and adequate exercise. These concepts - which combine reduced food intake and increased energy output - offer what appears to be the most effective way to control obesity on a long range basis. Sensible weight reduction is a slow process which may require some individuals to restrict caloric intake life-long. Crash or fad diets, while they have an appeal based on gimmicks or seemingly fast results, may fail to address the underlying problem which caused obesity or overweight in the first instance.

(1) It is the position of the Pennsylvania Medical Society that treatment of obesity is most certainly a medical concern;

(2) That obesity is best treated in a total milieu which analyzes the patient in terms of his physical, social, and emotional condition;

(3) That proper diagnosis and treatment of obesity can be accomplished through continued efforts to inform and educate;

(4) That the public should be protected against a rational therapy including inappropriate use of drugs or other selected methods of weight loss such as dietary supplements, which enjoy sudden and brief popularity and are often without final proof of medical soundness."

(Secretary's Note: Substitute resolution 77-21 was adopted.)

5. Resolution 77-23: The Physician Assistant (Delegates' Packet)
Subject: The Physician Assistant
Introduced by: Arlington A. Nagle, M.D., Secretary, on behalf of the Berks County Medical Society
Author: Arlington A. Nagle, M.D., Secretary, on behalf of the Berks County Medical Society

WHEREAS, Confusion exists concerning the duties of a physician assistant; and

WHEREAS, There is no good definition of a physician assistant; and

WHEREAS, There are no delineations of physician assistant activities and duties; therefore be it

RESOLVED, That Pennsylvania Medical Society draw up guidelines for the duties of the physician assistant; and be it further

RESOLVED, That one of these guidelines be that every county medical society review the educational training of the physician assistant and review the protocol under which the physician will function; and be it further

RESOLVED, That the Pennsylvania Medical Society produce clarification of the status of the physician assistant for all the areas in which the physician assistant functions.

(Financial Note: No financial impact.) Requires two-thirds vote.

Testimony at your reference committee hearing supported the principle of this resolution. We believe that amendments to the resolution will strengthen its intent. We therefore offer the following amended resolution:

"RESOLVED, That the Pennsylvania Medical Society draw up guidelines for the duties of the physician assistant; and be it further

RESOLVED, That the Pennsylvania Medical Society provide clarification on the status of the physician assistant for all the areas in which they function under the direct supervision of a licensed physician; and be it further

RESOLVED, That the Society initiate appropriate legislative action that will bring about the regulation and control of physicians' assistants."

Mr. Speaker, we recommend the adoption of Resolution 77-23 as amended.

6. Resolution 77-42: Community Mental Health Centers (Delegates' Packet)
Subject: Community Mental Health Centers
Introduced by: Robert S. Pressman, M.D., Philadelphia County Medical Society
Author: Bernard M. Blum, M.D., Philadelphia County Medical Society

WHEREAS, Community mental health centers (CMHC) have in recent years been organized across the nation; and

WHEREAS, According to a report presented earlier this year at a State Meeting of the Philadelphia Psychiatric Society which meeting was attended by Dr. Robert Daly, Deputy Secretary of Welfare, and Commissioner of Mental Health of the Commonwealth of Pennsylvania, who offered no modification of this facts stated hereunder, 70% of the so called professional staff of the CMHCs comprising social workers, psychologists, and others who serve in an actual treatment capacity have educational achievement only to the Bachelor or Master degree levels; and

WHEREAS, The role of physician/psychiatrist on the staff of CMHCs is primarily that of teaching and supervising the non-M.D. staff members and prescribing medication when necessary; and

WHEREAS, It is therefore clear that the vast majority of patients of such CMHCs have received inadequate care; and

WHEREAS, It was also noted at the above mentioned meeting that the cost per patient visit to a CMHC is approximately $90, which cost is much higher than the cost of care in a private office of a qualified, board certified psychiatrist; and

WHEREAS, The costs of operating CMHCs are paid for by tax dollars, both state and federal and

WHEREAS, The quality of care received by patients now treated at CMHCs could be greatly improved and millions of dollars of tax funds now being expended could be saved; therefore be it

RESOLVED, That the Pennsylvania Medical Society urge that

the present system of community mental health centers be re-examined, re-evaluated in the light of the facts stated above, and that full consideration be given to alternative methods of rendering psychiatric care to the people of the Commonwealth of Pennsylvania with a view to improving the quality of care to our citizens and to reducing the tax burden upon our taxpayers; and be it further

RESOLVED, That a copy of this resolution be forwarded to the House of Delegates of the American Medical Association for its deliberation.

(Financial Note: No financial impact.) Requires two-thirds vote.

Your reference committee agrees with the testimony that this is a critical issue and that our Society should support with the Pennsylvania Psychiatric Society a re-examination and re-evaluation in the community mental health centers.

Mr. Speaker, we recommend the adoption of Resolution 77-42.

7. Resolution 77-44: Preparation of Minorities for Medical School Admission (Delegates' Packet)

Subject: Preparation of Minorities for Medical School Admission

Introduced by: George A. Tushim, M.D., on behalf of the Clinton County Medical Society

Author: George A. Tushim, M.D.

WHEREAS, Medical education is most demanding and requires many talents and abilities in the students; and

WHEREAS, High quality medical care can only be produced by quality physicians; therefore be it

RESOLVED, That affirmative action plans to bring minority members into the profession take the form of preparing the aspiring student to meet the general requirements for admission to medical school and not lower the accepted standards to accommodate the students.

(Financial Note: No financial impact.) Requires three-fourths vote.

The testimony before your reference committee was sympathetic to the intent of this resolution. Your reference committee feels that an alteration in the wording of the resolved would clarify its intent.

"RESOLVED, That the Pennsylvania Medical Society support programs that prepare minority aspiring pre-medical students prior to their admissions to meet the general requirements for admission to medical schools."

Mr. Speaker, we recommend the adoption of the amended Resolution 77-44.

REFERENCE COMMITTEE GOVERNMENTAL RELATIONS

Donald G. Crawford, M.D. (Dauphin), Chairman, presented the following report of the Committee:

Mr. Speaker, the Reference Committee on Governmental Relations has considered all of the material listed in the Index.

1. Waiver of debate

The report of the Council on Governmental Relations reflects a great deal of work and the Council should be complimented.

Your reference committee has grouped the two reports together in a waiver of debate list. In each instance there was no testimony heard, and the Committee feels that the items are of a non-controversial nature:

Report of the Council on Governmental Relations (Official Reports Book, page 65)

Supplemental Report of the Council on Governmental Relations (Delegates' Packet)

Mr. Speaker, we recommend that the above two items be filed.

2. Resolution 77-9: Liability for Development of Products to Reduce Health Hazards (Delegates' Packet)

Subject: Liability for Development of Products to Reduce Health Hazards

Introduced by: Matthew Marshall, Jr., M.D., Allegheny County Medical Society

Author: Matthew Marshall, Jr., M.D.

WHEREAS, The use of TRIS in children's nightwear undoubtedly has saved many children from death or disfigurement from burns; and

WHEREAS, TRIS has been removed from the market because of possible carcinogenic effects at great cost to the companies associated with the development, manufacture, and marketing of this substance; and

WHEREAS, An example of financial disaster for developing a product in good faith and in accordance with federal regulations to reduce the proven health hazard can discourage these and/or other companies from future or similar efforts because of the risk of product liability or sudden mandate of withdrawal of the product due to unsuspected health hazards; therefore be it

RESOLVED, That the PMS commend the manufacturers and marketers of TRIS for their contribution to the reduction of death or disfigurement of children due to burning; and be it further

RESOLVED, That the PMS express to the federal government its concern that the example of a severe financial loss due to the uncompensated and unexpected ban on the use of TRIS in children's nightwear may discourage manufacturers from marketing products to improve the public health or safety because of such risk or their exposure to public liability suits thus reducing the availability or increasing the costs of developing such products; and be it further

RESOLVED, That PMS introduce a resolution to request the AMA to sponsor federal legislation requiring the federal government to assume or share liability for loss incurred by individuals or companies complying in good faith that public health or safety regulations that are subsequently withdrawn, reversed, or cause them to sustain substantial loss or liability from personal damage from product liability suits.

(Financial Note: No financial impact.) Requires two-thirds vote.

Your reference committee heard a great deal of testimony, both pro and con, on this resolution. We were informed by the sponsor that the purpose of the resolution is to urge the government to be less cavalier in treating the manufacturers when action is taken. We also heard testimony that companies should, in fact, be responsible for the safety of their products. It is your committee's feeling that the ramifications of this resolution are extremely far reaching and could convey to the public, if adopted, that the Medical Society would appear to support cancer-causing agents.

Mr. Speaker, your reference committee recommends rejection of Resolution 77-9.

A motion was then made from the floor by the author of Resolution 77-9 to adopt substitute Resolution 77-9.

(Secretary's Note: This substitute resolution reads as follows:

"WHEREAS, The use of TRIS in children's nightwear undoubtedly has saved many children from death or disfigurement from burns; and

WHEREAS, TRIS has been removed from the market because of possible carcinogenic affects at great cost to the companies associated with the development, manufacture, and marketing of this substance; and

WHEREAS, An example of financial disaster for developing a product in good faith and in accordance with federal regulations to reduce a proven health hazard can discourage these or other companies from future similar efforts because of the risk of product liability or sudden mandate or withdrawal of the product due to unsuspected health hazards; therefore be it

RESOLVED, That the PMS commend the manufacturers and marketers of TRIS for their contribution to the reduction of death and disfigurement of children due to burning; and be it further

RESOLVED, That the PMS express to the federal government its concern that the example of a severe financial loss due to the uncompensated and unexpected ban on the use of TRIS in children's nightwear may discourage the manufacturers from marketing products to improve the public health or safety because of such risks or their exposure to public liability suits thus reducing the availability or increasing the costs of developing such products; and be it further

RESOLVED, That PMS introduce a similar resolution including a request that the AMA sponsor federal legislation requiring the federal government to assume or share liability for loss incurred by individuals or companies complying in good faith with public health or safety regulations that are subsequently withdrawn or reversed.")

(Secretary's Note: Substitute Resolution 77-9 was adopted.)

3. Resolution 77-10: Legal and Disciplinary Powers for County Medical Societies (Delegates' Packet)

Subject: Legal and Disciplinary Powers for County Medical Societies

Introduced by: Robert B. Stuart, M.D., Executive Secretary, on behalf of the Erie County Medical Society

Author: Robert B. Stuart, M.D., Executive Secretary, on behalf of the Erie County Medical Society

WHEREAS, Professional people, and in particular physicians, are expected to supervise the practice of each of their own peers; and

WHEREAS, The public appears to expect that physicians will, in fact, supervise themselves; and

WHEREAS, Recent legal decisions, for the most part, remove from the Society any type of influence that an organized medicine group may have over an individual physician with the exception of moral influence; and

WHEREAS, The only major influential group in which physicians are involved is the State Board of Medical Education and Licensure; and

WHEREAS, It may be possible for local physicians to influence the actions of their fellow physicians if it were known that the local medical society had more than moral supervision; therefore be it

RESOLVED, That the State Medical Society begin discussions with the State Board of Medical Education and Licensure with the intent of investing local county medical societies with effective legal and disciplinary powers.

(Financial Note: No financial impact.) Requires two-thirds vote.

Your reference committee received excellent testimony from representatives of the State Board of Medical Education and Licensure, the Society's legal counsel, and others interested in the subject of the resolution. It is obvious to your reference committee that if monies owed to the State Board of Medical Education and Licensure by the Commonwealth were forthcoming, the State Board of Medical Education and Licensure would be much further along the way toward dealing with improper medical practice. The Society's legal counsel very clearly spelled out the constitutional problems connected with having medical societies involved in license revocations, and the inability of a government agency, as the State Board is, to delegate its authority. Your reference committee was impressed with the sponsor's aims - that of assisting physicians in need of rehabilatative help. Accordingly, your reference committee offers the following substitute resolution:

"RESOLVED, That the Pennsylvania Medical Society continue discussions with the State Board of Medical Education and Licensure with the intent of investigating means of joint action in developing effective mechanisms to promptly deal with disciplinary problems."

Mr. Speaker, your reference committee recommends the adoption of substitute Resolution 77-10.

4. Resolution 77-30: AMA Support of National Health Insurance/Care Legislation (Delegates' Packet)

Subject: AMA Support of National Health Insurance/Care Legislation

Introduced by: Harold J. Byron, M.D., Delegate, Montgomery County Medical Society

Author: James L. Pendleton, M.D., Member, Montgomery County Medical Society

WHEREAS, The Comprehensive Health Care Insurance Act of 1977 (H.R.-1818) provides for compulsory insurance coverage when a free competitive system has already almost completed such coverage; and

WHEREAS, Said act establishes a politically appointed health insurance board and unlimited bureaucratic structure to involve itself without significant limit in the "utilization of available financial resources health manpower and facilities"; and

WHEREAS, Government medical programs have repeatedly proved significantly more expensive than similar services provided by the private sector; and

WHEREAS, Government controls through PSRO and certificate of need have been extensive and have not proven valuable in improving quality of economy of care; therefore be it

RESOLVED, That the Delegation of the Pennsylvania Medical Society introduce and support at the next meeting of the House of Delegates of the American Medical Association a resolution to withhold support of the American Medical Association from the Comprehensive Health Care Insurance Act of 1977 or any other legislation that will contribute to government control of medical care; and be it further

RESOLVED, That if the House of Delegates of the AMA votes against the above or a similar resolution, the Pennsylvania Medical Society Delegation shall introduce and support a resolution for a vote by the AMA membership regarding AMA support of such legislation, the vote to be carried out by mail ballot with accompanying written material on the issue prepared by proponents and opponents of AMA support of such legislation

(Financial Note: No financial impact.) Requires two-thirds vote.

Your reference committee wishes to compliment the author of this resolution, James L. Pendleton, M.D., a member of the Montgomery County Medical Society, for his exhaustive research into not only H.R.-1818, the AMA sponsored "Comprehensive Health Care Insurance Act," but other proposals that are before the Congress. Dr. Pendleton put on a very interesting slide presentation for the committee. The committee also heard testimony from doctors who are active with the AMA's legislative process, and it became obvious that even though some of the features of the bill may be undesirable, the AMA had to introduce legislation into the Congress which is discussing the entire issue.

Mr. Speaker, your reference committee recommends rejection of Resolution 77-30.

REFERENCE COMMITTEE MEDICAL SERVICE "A"

R. Robert Tyson, M.D. (Philadelphia), Chairman, presented the following report of the committee:

Mr. Speaker and members of the House of Delegates: The Reference Committee on Medical Service "A" has considered all of the reports and resolutions listed in the above Index. Your reference committee has grouped the following items together in a waiver of debate list. In each instance, there was little or no testimony heard and the committee feels the item is of a non-controversial nature.

1. Report, Ad Hoc Committee to Study Malpractice Insurance, from Report of the Board of Trustees (Official Reports Book, page 21) (File)

Report, Malpractice, from Report of the Board of Trustees (Official Reports Book, page 22) (File)

Report of the Council on Medical Service (Official Reports Book, pages 67-76) (File)

Supplemental Board Report A - Status of Argonaut Suit Section (Official Reports Book, page 86) (File)

Supplemental Board Report A - Results of PMS Intervention in the Rate Increase Hearings for Argonaut, ISO, and the JUA Section (Official Reports Book, pages 86-87) (File)

Mr. Speaker, your reference committee recommends that the above items be filed.

2. Resolution 77-3: Standardized Informed Consent (Official Reports Book, page 88)

Subject: Standardized Informed Consent

Introduced by: Robert W. Allen, M.D., Secretary, on behalf of the Mercer County Medical Society

Author: Robert W. Allen, M.D.

WHEREAS, What a physician tells a patient before a medical or surgical procedure is part of the practice of medicine; and

WHEREAS, Physicians and physicians alone should set standards for informed consent; and

WHEREAS, Physicians should decide what is reasonable and what is best from a medical point of view to tell their patients before a medical or surgical procedure; and

WHEREAS, If all physicians doing the same procedure are using the same informed consent, a consent form devised by physicians, then this will be the standard of medical practice; therefore be it

RESOLVED, That the Pennsylvania Medical Society recommend to the state specialty societies that they appoint physicians to rate standards of informed consent for their specialty.

(Financial Note: Financial impact dependent upon cost involved in developing guidelines with legal counsel.)

Your reference committee was intrigued with the intent of this resolution and feels that there should be further study of the problem for possible methods of implementation.

Mr. Speaker, your reference committee recommends referral of Resolution 77-3 to the PMS Interspecialty Committee.

3. Resolution 77-14: Membership Benefit (Delegates' Packet) and Resolution 77-27: Non-PMS Member Argonaut Policyholders

Subject: Membership Benefit

Introduced by: Wallace O. Lecher, Jr., M.D., Secretary, on behalf of the Delaware County Medical Society

Author: Wallace O. Lecher, Jr., M.D., Secretary, on behalf of the Delaware County Medical Society

WHEREAS, PMS has sponsored a professional liability insurance program since 1971; and

WHEREAS, This professional liability insurance program has been promoted as a PMS membership benefit; and

WHEREAS, It has been reported that non-dues paying members have been accepted by Argonaut Insurance Company; therefore be it

RESOLVED, That this House of Delegates reaffirm its policy that only PMS members receive Argonaut coverage through PMS membership.

(Financial Note: No financial impact.) Requires two-thirds vote.

Resolution 77-27

Subject: Non-PMS Member Argonaut Policyholder

Introduced by: Montgomery County Medical Society Delegation

Author: Samuel F. Cohen, M.D., Montgomery County Medical Society

WHEREAS, It is known that about 400 non-PMS members are Argonaut policyholders; and

WHEREAS, Argonaut malpractice liability insurance is stipulated a PMS membership benefit; therefore be it

RESOLVED, That Argonaut insurance be denied non-members.

(Financial Note: No financial impact.) Requires two-thirds vote.

These two resolutions spoke to the issue of Argonaut insurance being a membership benefit. Resolution 77-14 spoke to the issue directly and your reference committee recommends approval of Resolution 77-14 in lieu of Resolution 77-27.

Mr. Speaker, your reference committee recommends approval of Resolution 77-14.

Mr. Speaker, your reference committee recommends that Resolution 77-27 be filed.

4. Resolution 77-22: Surreptitious Argonaut Policyholders (Delegates' Packet) and Resolution 77-26: Collection of Dues from Non-Member Argonaut Policyholders (Delegates' Packet)

Resolution 77-22

Subject: Surreptitious Argonaut Policyholders

Introduced by: Samuel S. Faris, II, M.D., Montgomery County

Author: Samuel S. Faris, II, M.D., Montgomery County

WHEREAS, Over 400 non-PMS member physicians own Argonaut malpractice policies; and

WHEREAS, Such ownership is a stipulated PMS member only benefit; and

WHEREAS, Annual PMS dues not collected for 400 physicians represents $60,000; and

WHEREAS, It is arguable that surreptitious policyholders may attract excessive litigation; therefore be it

RESOLVED, That a census of such litigation be held, and if excessive; be it further

RESOLVED, That a premium correction occur to regular policyholders and that county assignment of Argonaut malpractice incidents be revised.

(Financial Note: Based on a full active membership at the current assessment, the loss experienced would be $250 per member.) Requires two-thirds vote.

Resolution 77-26

Subject: Collection of Dues from Non-Member Argonaut Policyholders

Introduced by: Montogomery County Medical Society Delegation

Author: Samuel F. Cohen, M.D., Delegate, Montgomery County Medical Society

WHEREAS, It is known about 400 non-PMS members are Argonaut policyholders; and

WHEREAS, Argonaut malpractice liability insurance is stipulated a PMS membership benefit; therefore be it

RESOLVED, Those non-members currently enrolled be assessed for PMS and respective county society dues for the years they have had Argonaut insurance.

(Financial Note: No financial impact.) Requires two-thirds vote.

The implementation of the Pennsylvania Medical Society Liability Insurance Company (PMSLIC) makes the intent of Resolutions 77-22 and 77-26 somewhat of a moot question, particularly in light of the difficulties that might be encountered to accomplish their purpose.

Mr. Speaker, your reference committee recommends rejection of Resolution 77-22.

Mr. Speaker, your reference committee recommends rejection of Resolution 77-26.

5. Resolution 77-17: Insurance Commissioner (Delegates' Packet)

Subject: Insurance Commissioner

Introduced by: Wallace O. Lecher, Jr., M.D., Secretary, on behalf of the Delaware County Medical Society

Author: Wallace O. Lecher, Jr., M.D., Secretary, on behalf of the Delaware County Medical Society

WHEREAS, The Insurance Commissioner of the Commonwealth of Pennsylvania testified before the Insurance Committee, Senate of Pennsylvania, on July 10, 1975 and stated, "Before getting to the particulars, I would like to state what I consider to be the three main objectives of legislation in this area. First, we must assure that every health care provider in Pennsylvania has access to adequate professional liability insurance. That is not the case today. Second, we must take steps to reduce the overall cost of medical malpractice insurance by reducing the cost of claims and

of procedures required for adjusting claims"; and

WHEREAS, The availability of professional liability insurance for health care providers is not now a problem in 1977; therefore be it

RESOLVED, That this House of Delegates request the Board of Trustees of the Pennsylvania Medical Society to inquire what, if any, regulations have been implemented through the offices of the Insurance Commissioner, Commonwealth of Pennsylvania, to reduce the cost of claims and procedures required for adjusting claims by carriers underwriting professional liability insurance in the Commonwealth of Pennsylvania.

(Financial Note: No financial impact.) Requires two-thirds vote.

All testimony heard was in favor of this resolution.

Mr. Speaker, your reference committee recommends approval of Resolution 77-17 with referral to the PMS Board of Trustees for implementation.

Resolution 77-19: Recommendations to Relieve the Malpractice Crisis (Delegates' Packet)

Subject: Recommendations to Relieve the Malpractice Crisis

Introduced by: Eugene B. Rex, M.D., Otolaryngology and Maxillofacial Surgery

Author: Eugene B. Rex, M.D., Otolaryngology and Maxillofacial Surgery

WHEREAS, The Medical Malpractice Act has accomplished nothing to relieve the malpractice crisis, and this act has failed to reduce the incidence of suits, frivolous or otherwise; and

WHEREAS, Premiums continue to escalate, and such exorbitant premiums inflate medical costs without improving medical care; and

WHEREAS, The diligent and best efforts of the PMS have been futile to date; therefore be it

RESOLVED, That the PMS Board of Trustees implement the following recommendations of the Interspecialty Committee:

1. That all malpractice cases involving specialty members be submitted for review to a Professional Liability Committee to be established by each specialty. The Professional Liability Committee will be empowered to select from the specialty membership three physicians whom they feel most eminently qualified to review the presented case. The recommendations of such a peer review committee will be made available to the involved physician, the defendant's lawyer and insurance carriers, and the arbitration panel through the PMS. The three panelists may be called as expert witnesses both before the arbitration panel and the jury, if it goes that far. Any cases involving possible abuse of due process, etc., will be referred to PMS;

2. All claims should be reported to the Professional Liability Committee, stating the name of the plaintiff, the plaintiff's lawyer, and, as soon as available, the name or names of any so called expert witness on the plaintiff's side, the name of the physician who reviewed the chart for the plaintiff's lawyer, and any other information which the member physician feels might be helpful in determining what law firms and which doctors aid and abet plaintiff attorneys. All such information will be forwarded to PMS;

3. If any physician member feels that he has not had a fair trial due to incompetent legal counsel, the admission of false or misleading medical information, perjury by a medical or other witness, departure from points of law, or intimidation by the court, he should present a resume to the committee;

4. To satisfy the criteria of peer review, the Professional Liability Committee will forward, in confidence, names and circumstance of any suit in which it is felt that gross negligence or serious incompetence has been demonstrated, to the president of the specialty academy for review, and, if indicated, further action;

5. Each case should be carefully evaluated for champerty and maintenance. This involves the seeking and simulation of litigation and "a proceeding by which a person not a party in a suit bargains to aid in or carry on its prosecution or defense in consideration of a share of the matter in suit";

6. Frivolous, nuisance, or suits of vindictive nature will be referred to PMS for countersuit against lawyer and plaintiff. The PMS will also refer such cases to respective county medicolegal committee for action and to the State Bar Association;

7. The PMS should establish a medicolegal committee (in contradistinction to malpractice committee) with a competent independent trial lawyer who is employed only by the PMS to represent members' interests in these matters; and be it further

RESOLVED, That such implementation can best be achieved by a competent lawyer employed only by the PMS who shall be charged with complying with the intent and will of these recommendations.

(Financial Note: Financial impact undetermined, but of considerable magnitude.) Requires two-thirds vote.

There was considerable discussion, mostly favorable, concerning this rather detailed resolution. Dr. Masland informed the reference committee that these issues are already favorably being considered by the PMSLIC Board. Your reference committee recognizes that there needs to be careful consideration and a detailed evaluation of all of these issues.

It was pointed out that item #6 in the first resolved was inappropriate and the author agreed to its deletion.

Mr. Speaker, your reference committee recommends approval of Resolution 77-19 as amended by deletion of item #6 in the first resolved, with referral to the PMS Board of Trustees for consideration and appropriate referral.

(Secretary's Note: A motion was made from the floor to amend the reference committee recommendation as follows: "Mr. Speaker, your reference committee recommends referral of Resolution 77-19, as amended by deletion of item #6 in the first resolved, to the PMS Board of Trustees for consideration and appropriate referral." This motion passed.)

6. Supplemental Board Report D - PMSLIC (Delegates' Packet)

Your reference committee recognizes that a great deal of effort has gone into the preparation of this report and the implementation of PMSLIC by our Society. This report was the subject of considerable discussion, the majority of which was favorable to the report and to the method of funding. In spite of all the discussion, and the fact that this issue has been before the House of Delegates and the members of the Society for some time, it was evident that there is still some misunderstanding of the basic premise of forming a captive insurance company. Your reference committee feels it is essential that there be an all out effort to carry this information by the most direct means possible to all members of this Society.

Mr. Speaker, your reference committee recommends approval of the first resolved for an assessment of $250 per active member.

Mr. Speaker, your reference committee recommends approval of the selective assessments as listed in the second resolved.

Mr. Speaker, your reference committee also recommends approval of third resolved.

In view of the extreme importance of rapidly disseminating information concerning PMSLIC to the members of the Pennsylvania Medical Society, Mr. Speaker, your reference committee recommends that the Board of Trustees utilize whatever means are necessary to correct misunderstandings and assure that each member is adequately informed about PMSLIC.

7. Resolution 77-36: PMSLIC Board of Directors (Delegates' Packet)

Subject: PMSLIC Board of Directors

Introduced by: Wallace O. Lecher, Jr., M.D., Secretary, on behalf of the Delaware County Medical Society

Author: Wallace O. Lecher, Jr., M.D., Secretary

WHEREAS, The present book of business of Argonaut consists of approximately 4,700 policyholders; and

WHEREAS, Territory I is comprised of Delaware, Montgomery, and Philadelphia County Medical Societies; Territory IV is comprised of Bucks and Chester County Medical Societies; Territory III is comprised of Allegheny County Medical Socety; and Territory II is the remainder of the State of Pennsylvania; and

WHEREAS, It has been reported that Territory I has the largest concentration of Argonaut subscribers in the Argonaut portfolio; and

WHEREAS, The present make-up of the PMSLIC Board has only one physician representing the physicians in Territory I; therefore be it

RESOLVED, If PMSLIC becomes operational and writes professional liability insurance, it is recommended that the House of Delegates inform and urge the PMS Board of Trustees that the Board of Directors of PMSLIC be composed on a territorial basis rather than the will of the Board of Trustees of the Pennsylvania Medical Society.

(Financial Note: No financial impact.) Requires two-thirds vote.

There was considerable discussion concerning this resolution that suggested there should be a broad based representation on any future PMSLIC Board. Dr. Masland informed the reference committee that this thought had already been recognized by the PMSLIC Board and that implementation was underway. Since Resolution 77-36 addresses only one aspect of PMSLIC Board composition, your reference committee recommends a substitute resolve:

"RESOLVED, If PMSLIC becomes operational and writes professional liability insurance, it is recommended that the House of Delegates advise the PMS Board of Trustees that the Board of Directors of PMSLIC should have representation from the various risk classes, the geographic distribution of PMSLIC insureds, and members of the Pennsylvania Medical Society, making sure to include knowledgeable and interested members of the Medical Society to the greatest extent possible."

Mr. Speaker, your reference committee recommends approval of the substitute resolution.

8. Supplemental Report, Council on Medical Service (Delegates' Packet)

There was no discussion concerning this report. Your reference committee recommends approval of the recommendations of the Council's Commission on Professional Liability Insurance.

Mr. Speaker, your reference committee recommends approval of the recommendations contained in the Supplemental Report of the Council on Medical Service.

9. Resolution 77-28: Interest Funds of Arbitration Panel (Delegates' Packet) and Resolution 77-32: Medical Malpractice Arbitration Fund (Delegates' Packet)

Resolution 77-28

Subject: Interest Funds of Arbitration Panel
Introduced by: Montgomery County Medical Society Delegation
Author: Edgar W. Kline, M.D., Delegate, Montgomery County Medical Society

WHEREAS, On September 29, 1977, Pennsylvania Commonwealth Arbitration Panel Administrator Paul Abrams stated that the annual bank interest on the physician contributed arbitration fund is remitted to the Commonwealth's General Fund; therefore be it

RESOLVED, That protest be made that these earnings be returned to the Arbitration Fund.

(Financial Note: No financial impact.) Requires two-thirds vote.

Resolution 77-32

Subject: Medical Malpractice Arbitration Fund
Introduced by: Wallace O. Lecher, Jr., M.D., Secretary, on behalf of the Delaware County Medical Society
Author: Wallace O. Lecher, Jr., M.D.

WHEREAS, Paul F. Abrams, Administrator for Arbitration Panels for Health, reported on September 29, 1977 at the joint meeting of medical-legal committee symposium of Delaware County that "our receipts for the 1976 billing period have totalled approximately $1,350,000, and to date, for the 1977 period, approximately $1,295,000 for a total of $2,645,000; and

WHEREAS, It was reported that the interest income received from the investants of these monies has been returned to the General Fund of the Commonwealth of Pennsylvania; therefore be it

RESOLVED, That the House of Delegates request the Board of Trustees of the Pennsylvania Medical Society to prepare proper legislation or administrative amendments to ensure that the interest income is returned to the medical malpractice arbitration fund and not to the General Fund of the Commonwealth of Pennsylvania.

(Financial Note: No financial impact.) Requires two-thirds vote.

There was minimal discussion concerning these issues, all favorable to the intent of the resolutions. Your reference committee felt that Resolution 77-32 spoke more clearly to the issue.

Mr. Speaker, your reference committee recommends approval of Resolution 77-32.

Mr. Speaker, your reference committee recommends that Resolution 77-28 be filed.

10. Resolution 77-29: Locale of Malpractice Incidents (Delegates' Packet)

Subject: Locale of Malpractice Incidents
Introduced by: Montgomery County Medical Society Delegation
Author: Samuel S. Faris, II, M.D., Delegate, Montgomery County Medical Society

WHEREAS, Precise statistical recording is a goal of scientific methods; therefore be it

RESOLVED, That said or real malpractice incidents be attributed to the county where they occur.

(Financial Note: No financial impact.) Requires two-thirds vote.

This resolution speaks clearly to the proper recording of malpractice incidents with respect to where the incident occured. Although there was not a great deal of discussion, all discussion was favorable.

Mr. Speaker, your reference committee recommends approval of Resolution 77-29.

11. Resolution 77-34: Report of the 1006 Joint Committee (Delegates' Packet)

Subject: Report of the 1006 Joint Committee
Introduced by: Wallace O. Lecher, Jr., M.D., Secretary, on behalf of the Delaware County Medical Society
Author: Wallace O. Lecher, Jr., M.D.

WHEREAS, Act 111 "Health Care Service Malpractice Act" was signed and approved the 15th day of October, A.D., 1975 by the Honorable Milton J. Shapp, Governor, Commonwealth of Pennsylvania; and

WHEREAS, The 1006 Joint Committee held hearings during the year of 1976; and

WHEREAS, Act 111 states, "The Committee shall promulgate a proposed code of ethics with suggested legal sanctions to deal with any violators of the code of ethics on or before July 1, 1976"; and

WHEREAS, Act 111 states, "The Committee shall also study all phases and the financial impact of the operations of the medical professional liability catastrophe loss fund and shall report its findings and recommendations to the General Assembly on or before July 1, 1977"; and

WHEREAS, The Delaware County Medical Society has requested a copy of the report of the 1006 Joint Committee from its

legislators and to date has been informed that the report has not been typed; therefore be it

RESOLVED, That the House of Delegates request the Board of Trustees of the Pennsylvania Medical Society to request the Governor to urge the Legislature to follow the law of the land and have this report of the 1006 Joint Committee finalized and distributed to all interested parties.

(Financial Note: No financial impact.) Requires two-thirds vote.

The discussion of Resolution 77-34 was limited, however, all favorable. There was no report available.

Mr. Speaker, your reference committee recommends approval of Resolution 77-34.

12. Resolution 77-37: Professional Liability Insurance (Delegates' Packet)
Subject: Professional Liability Insurance
Introduced by: Wallace O. Lecher, Jr., M.D., Secretary, on behalf of the Delaware County Medical Society
Author: Wallace O. Lecher, Jr., M.D., Secretary

WHEREAS, Paid advertisements appeared in PENNSYLVANIA MEDICINE during the year 1972, Pennsylvania Medical Society sponsor, Argonaut Insurance Company, underwriter, Parker & Company, Inc., of Pennsylvania, administrator, with seven key features of the program; and

WHEREAS, Third key feature stated "State Society peer review of individual claim or suit settlement disputes"; and

WHEREAS, Sixth key feature stated "Extensive involvement of State Society in underwriting, claims, classification, statistics, and rate-making developments"; and

WHEREAS, Seventh key feature stated "Planned program of continuing education and malpractice claims avoidance and prevention"; therefore be it

RESOLVED, That the House of Delegates request the Board of Trustees of the Pennsylvania Medical Society to report the number of individual claims that they have peer reviewed by PMS and to report the number of claims by county, number of claims by class, and the number of incidents by county for the period of 1971-1976 which has been administered by Frank B. Hall & Company, Inc., and underwritten by Argonaut Insurance Company.

(Financial Note: No financial impact.) Requires two-thirds vote.

This resolution calls attention to a stated function in the Argonaut agreement which has been only minimally implemented over the past seven years. Your reference committee believes this is an important item in loss control and represents a failure of Argonaut to carry out their contractual obligations.

Mr. Speaker, your reference committee recommends approval of Resolution 77-37.

12. Resolution 77-43: Frank B. Hall & Company of Pennsylvania, Inc. (distributed to the House)
Subject: Frank B. Hall & Company of Pennsylvania, Inc.
Introduced by: Howard A. Richter, M.D., Delaware County
Author: Howard A. Richter, M.D.

WHEREAS, Frank B. Hall has been the administrator of the PMS-Argonaut professional liability insurance program during the past two crisis-ridden years; and

WHEREAS, Hall has favored the Insurance Company over the insured members of PMS; therefore be it

RESOLVED, That PMS no longer employ Hall as its insurance broker or administrator.

(Financial Note: No financial impact.) Requires two-thirds vote.

After some discussion of this resolution, the author, Howard A. Richter, M.D. agreed to the withdrawal of this resolution.

Mr. Speaker, your reference committee recommends that leave to withdrawal be accorded.

ELECTION OF ALTERNATE DELEGATE TO THE AMA

At this time, the election was held for an alternate delegate to the AMA to fill Dr. R. Robert Tyson's one-year unexpired term. The following were nominated from the floor of the House:

Doris Bartuska, M.D. (Philadelphia)
Charles Heisterkamp, III, M.D. (Lancaster)
John L. Kelly, M.D. (Delaware)
William J. Mitchell, M.D. (Fayette)

(Secretary's Note: John L. Kelly, M.D. (Delaware) was elected to fill Dr. Tyson's one-year unexpired term.)

ANNUAL ASSESSMENT

Leroy A. Gehris, M.D., Chairman of the Finance Committee of the Board of Trustees and Councilors, presented the following report containing the recommendation of the Finance Committee that the annual assessment for full dues paying members be $225 for 1977.

"Mr. Speaker, members of the House of Delegates, as I mentioned when I appeared before you at the first session of this House, the Society is faced with a possible deficit for 1977 of at least $175,000. In addition, it is important to tell you that if the Pennsylvania Medical Society Liability Insurance Company does not get sufficient funds to become active, the Society will be responsible for the start-up costs which could total $200,000 and would create a deficit of almost $375,000 for this year.

"I need not go into detail at this time regarding all of the various projects and activities the Society will have which will continue to entail heavy expenditures. They have, I believe, been thoroughly discussed during the past three days.

"Since no new projects have been mandated by this House, our original projection of a deficit of $394,416 for 1978 still remains with us. It is the firm belief of the Board of Trustees that not only must we have sufficient funds to remain solvent and help to recuperate our losses for the current year, but also be in a position to project a sound financial situation for several years ahead.

"Accordingly, the Board of Trustees recommends that the 1978 annual assessment for active members of the Pennsylvania Medical Society be increased by $75 which would make the annual dues $225.

"Contingent upon the approval by the House of the 1978 assessment, the Finance Committee plans to introduce a resolution before the Board of Trustees which will recommend that 3.55 percent of the annual assessment be allocated to the Educational Fund of the Educational and Scientific Trust of the Pennsylvania Medical Society, which in the case of full dues paying members will be $8.00.

"The Finance Committee also plans to recommend to the Board of Trustees that of the annual assessment paid by each active dues paying member, .44 percent, or $1.00 in the case of full dues paying members, be allocated to the Medical Benevolence Fund.

"This means that $214 of the annual assessment of each full dues paying member will be available to the General Fund for operating expenses of the Society."

ANNOUNCEMENT

The Speaker announced that the Board of Trustees would reconvene for its reorganization meeting in the Monterey Room immediately following the adjournment of the House of Delegates.

ADJOURNMENT

It was moved and seconded that the House of Delegates be adjourned. The House was adjourned at 11:10 a.m.

Respectfully submitted,

D. Ernest Witt, M.D. Speaker	G. Winfield Yarnall, M.D. Secretary
Donald E. Harrop, M.D. Vice Speaker	Barbara M. Starr Assistant Secretary

Appendices

Appendix A

Annual Report
Pennsylvania Medical Political Action Committee

Mr. Speaker, when I spoke to the PMS House of Delegates last year, we were less than two months away from the General Election. I reported to you at that time that PaMPAC would be involved in more campaigns than ever before because of the growing political demand to present Medicine's viewpoints on a multitude of important issues such as medical malpractice, comprehensive health planning and many others.

Last year Pennsylvania physicians and spouses, through PaMPAC, contributed over $100,000 to 145 candidates including 64 Democrats and 81 Republicans. 86% of the candidates we supported won. Through AMPAC, the Pennsylvania medical community contributed an additional $45,000 in the U. S. Senate and Congressional races in Pennsylvania. This, of course, does not mean that organized medicine through its political action committees can simply financially support candidates to office and then have those winners become "puppets" of the medical community. What it means is that survival in the governmental relations jungle without political action is simply impossible. We must recognize that organized medicine needs to relate to government and be able to influence its decisions in order to protect its organization, to promote the interest of its members, and, more importantly, to promote better health care to the people. As a direct result of organized medicine's participation through PaMPAC, medicine will, hopefully, help develop influence within the political arena.

Contribution limits, disclosure requirements, and public attitudes toward campaign financing have drastically altered American politics. An individual can no longer influence the outcome of an election merely by writing a substantial check. In fact, we may well be just around the corner from the day when campaigns, at least for federal office, are totally financed through government subsidy, and even the small contributor will be extinct.

This approach of federal funding, of course, is just another effort to have big government take over individual and group participation. I don't have to tell you, as delegates, that the medical profession is fighting a continuous barrage of onslaughts from the federal government, the national media, and other outside forces. Your contributions to PaMPAC to help fight against the evils of big government were never more badly needed. PaMPAC knows that the problems that beset our profession today are never going to go away—they are with us year in and year out. The government will never cease trying to interfere with the practice of medicine. We have learned to live with the fact that our battle goes on continuously. We know that medicine must not put all of its eggs in one basket and rise or fall on one issue, or one political party. We must continually fight for the way of life in which we believe and for our right and obligation to treat patients in the way we see fit. We must continue to participate in politics in as open and honest an atmosphere as possible.

This is why we must continue to stress PaMPAC membership to, not only the entire House of Delegates, but to every member of the Pennsylvania Medical Society. Our membership rolls, over the past ten years, have remained at about 30% of PMS membership. We are talking about a $35 contribution of which $10 goes to AMPAC through a joint fund raising effort. To go one step further, I urge each member of this House, and you colleagues, to become sustaining members, with a $100 annual contribution.

On the brighter side of membership, I would like to point out that the Pennsylvania Medical Society Auxiliary, through a concerted effort of Mrs. Spencer Servoss, President of the Auxiliary, requested that the county auxiliaries contribute to PaMPAC so that it can help expand its political education programs and free up more of the membership contributions for direct candidate support. As a result of Mrs. Servoss' visits to the county auxiliaries, PaMPAC received $625 from 36 county auxiliaries. In addition, the PMS Auxiliary contributed $300 to PaMPAC, and $300 to AMPAC.

I cannot over-emphasize the importance of contributing to PaMPAC. Just remember this, politicians are always conscious of two events: The last election and the next election. Political people categorize everyone they deal with in very elementary terms: Group A—Those who can help or have helped him get elected; Group B—Those who could cause him to be defeated; and Group C—Everyone else (and they don't count). Physicians and spouses who participate in the political process are actually helping select the decision-makers and decision-influencers of government.

Finally, I'm not just asking you to contribute to PaMPAC, but I ask you as delegates to commit yourselves to politics as a way of life, and rank it as one of the most important activities to which you can commit your time and resources.

Thank you.

Appendix B

Annual Report
Pennsylvania Medical Cooperative

Two years ago to the month, amid both doubts and high expectations, the Pennsylvania Medical Cooperative opened its warehouse doors for business. Much has occurred during the brief life span of this unique, first of its kind organization, to surprise both the pessimist who thought it could not succeed and the optimist who thought that to succeed all that was necessary was to open the doors for business.

It was said the Co-op could not compete with the service provided by local suppliers. But it does. Some said it could not compete price-wise and offer the savings it had promised. But it does. Some said it was just a mail order house that would fail if it could not ship through an existing delivery service. That myth was shattered last year when the Co-op delivered on schedule throughout a rather lengthy UPS strike. There also was talk that the Co-op could not expand its product line to be a full service organization before competitors ran it out of business. The Co-op was full service in a little more than a year.

In spite of all the pluses we can give to the PMC, we can cite some problems. The optimists were not correct in their assumption that the success of the Cooperative was automatic. It's one thing to build a better mouse trap; it's another to inform your customers of its easy availability.

The Co-op learned very quickly that a commitment to membership in the organization was not necessarily a commitment to buy products. Just like any other business, we must actively and agressively sell our products to our members.

You might say, that the first year of Co-op life was a shakedown period. We learned what products physicians wanted, in what quantity and at what price. We learned that there are peak sales months and months that are rather slow. We learned how to promote the Co-op more effectively to the members. We learned there was a need for telephone ordering service and credit for our members. We adjusted to meet the situations and we improved.

Early estimates of expected sales before the Co-op opened its doors for business ranged in excess of a million dollars per year. That figure proved to be unrealistic. In 1976 total sales amounted to $500,000. The Co-op reevaluated both its marketing effort and

in its projected sales figures. The business became more sophisticated and more realistic in its expected growth. In 1977 the Co-op Board set a projected sales goal of $800,000 . . . $300,000 more than 1976. With more than two months to go in the calendar year, we are happy to report that that goal is within reach. Through proper marketing of the Co-op's new products and services we hope to reach still higher sales figures in the future.

The outstanding growth of the Co-op in 1977 was no accident. It was the result of the expansion of the product line from approximately 1,400 items to over 3,000 items. It was due in part to the addition of an executive to the staff to work full time in sales and promotion of the Co-op; to the establishment of limited credit for members; and to the establishment of a phone service to make it more convenient for members to use the Co-op.

And, much of the credit to the Co-op's growth must be attributed to the PMS House of Delegates and the action that it took in 1976 to assure appropriate support for PMC. Based on that House action last year, the Board of Trustees and Councilors in January authorized a loan of $50,000 to support Co-op expansion in the areas mentioned above.

In addition to our efforts to educate and sell Co-op members in Pennsylvania, the Co-op has expanded into one other state. Negotiations with the Summit County Medical Society in Ohio over the early months of 1977 resulted in an agreement to supply, through the PMC, products to physicians in Ohio. Now, Ohio physicians can take advantage of Co-op savings and at the same time the Co-op will experience greater inventory turnover which will improve its volume purchasing. Hopefully this concept will spread to still more states.

The two years that the Co-op has been operational have been a challenging and educational experience for the Board members and staff. We have grown with the Co-op. We have gained experience in selling to our physician market. We have sharpened our business senses to be more effective in negotiating prices with our suppliers. And we have gained confidence in our ability to manage this unique, first of its kind, organization anywhere in the country. Even though the Co-op is not out of the woods financially, we can look forward with more certainty than at any time in our brief history to a successful conclusion to this business venture. We know the Co-op is no longer an idea, but a hard, cold fact. We have survived! Now we will succeed.

The Pennsylvania Medical Cooperative would like to take this occasion to express its appreciation for the support the House of Delegates and the Board of Trustees and Councilors has given it through the years of the Co-op's formation and actual operation. We fully expect to pay dividends for this support in terms of increased membership and commitment to PMS.

Appendix C

Remarks

Sidney O. Krasnoff, M.D., President
Pennsylvania Medical Care Foundation

Mr. Speaker, Officers, Members of the Board of Trustees and Councilors, and members of the House of Delegates.

I have been searching vainly for an antonym for the word malpractice—a word with as much impact, a word that could cause a crisis generating an investment of untold man-hours on the part of busy and good practitioners of medicine as well as 1.5 million of their hard earned dollars over the past three years.

So, if I were to stand here and try to sell you "good practice" insurance you might laugh me out of the hall. Yet, in 1969 George Farrar, the 119th President of the Society, placed before you just such a proposition implying that we should get into the "good practice" business. Faced with that charge the PMS Council on Medical Service, in its wisdom, embarked upon the medical care appraisal project in 1971. For details I recommend that you refer to Appendix C of the Annual Report of the Pennsylvania Medical Care Foundation.

Unless my estimate is grossly incorrect, the majority of physicians in this Commonwealth still believe, as they did in 1969 and '70, that we should develop some system of rendering our services, with appropriate control of quality and with a method of financing that can meet the socio-economic demands of the day—a system which would afford the highest quality of medical care to all citizens of Pennsylvania and be mutually acceptable to the consumer and provider.

As a result of the incursion of P.L. 92-603, the Pennsylvania Medical Society chose to divert its original charge and directed the Foundation to support administratively, developmentally and educationally the 12 PSRO's of this Commonwealth. The time has come to return to our original dedicated purpose.

My experience as a member and officer of the Philadelphia County Medical Society, Pennsylvania Society of Internal Medicine and most of all as an individual practitioner of medicine has convinced me that the optimal approach to this quest for an alternative system can be found in the elements of the Individual Practice Association (IPA).

I do not believe it appropriate to detail the methods of entering into such an association, but so firmly do I believe that we must comprehend all the implications of the system that I urge you to support the recommendation of the Board of Directors of the Foundation—a unanimously approved recommendation by representatives of physicians, labor, industry, hospitals and recipients of our care—a structure mandated by the House of Delegates. The Foundation's Board of Directors firmly believes that it is the only qualified organization that can effect this recommendation.

Appendix D

Supplemental Report
Committee on Medical Benevolence

In August 1977, the Committee on Medical Benevolence reviewed the financial status of the Fund. The committee determined to submit the following recommendation to the Finance Committee:

> It was recommended that the current objective of the Fund growth and income be changed so that the Fund will realize the maximum amount of income annually in order to avoid the need of invading the principle.

In light of the Society's current fiscal problems, if this recommendation is approved, a $1.00 allocation from the dues would be sufficient to cover the expenses of the Medical Benevolence Committee.

Respectfully submitted,
Leroy A. Gehris, M.D.
Ralph K. Shields, M.D.
G. Winfield Yarnall, M.D.
Cyrus B. Slease, M.D., Chairman

Appendix E

Supplemental Report A
Board of Trustees and Councilors
Summary of Recommendations for Action

(1) The Board of Trustees unanimously supports the recommendation that the House of Delegates alter the section of the Bylaws requiring that PENNSYLVANIA MEDICINE publish the proceedings of the House of Delegates so that such publication is no longer mandatory.

(2) The Board of Trustees recommends that the House of Delegates give consideration as to whether or not a resolution be introduced at the AMA Clinical Session in the fall which advocates re-establishment of the AMA Committee on Quackery.

(3) In the same regard, the Board of Trustees further recommends that the House give consideration as to whether or not a resolution be introduced recommending that the AMA establish a nationwide quackery defense fund supported by voluntary contributions from physicians.

(4) The Board of Trustees recommends that the House of Delegates give consideration as to whether or not a resolution be introduced at the AMA Clincial Session which would re-establish the AMA Department of Investigation.

Publication of Proceedings

At the May 18 meeting of the Board of Trustees, the Board unanimously voted to go on record as favoring the elimination of the publication of the proceedings of the meetings of the House of Delegates.

This action was recommended to the Board by the Publication Committee, which has held several meetings during the past year in an effort to improve both the readership and the financial posture of PENNSYLVANIA MEDICINE. The committee reasoned that news coverage of the meeting would be more widely read and understood by the members than the official proceedings. The committee also was concerned with the cost of publishing the proceedings, which has risen every year, with the cost of paper alone up 50 percent over 1974.

The Board, therefore, recommends that the House of Delegates alter the section of the Bylaws requiring that PENNSYLVANIA MEDICINE publish the proceedings of the House of Delegates so that such publication is no longer mandatory.

We therefore recommend the following change in the Bylaws, Chapter III - House of Delegates:

SECTION 11.-Publication of Proceedings. The proceedings of the House of Delegates at the Annual Session, or any special session, [shall] may be published in the JOURNAL in the first possible issue following the session except that proceedings of Closed and Executive Sessions shall not be published. If the proceedings are not published, a full report of the session shall appear, and the official proceedings shall be available on request to members.

(Words underlined are being added. Words in brackets are being deleted.)

If the mandatory revision is removed, the news of the House of Delegates will be published in PENNSYLVANIA MEDICINE, and official proceedings, or minutes, will be made available to any member upon request.

Committee on Quackery

In the annual report of the Board it was noted that a class action civil suit was brought against the Pennsylvania Medical Society and eleven other organizations by a chiropractor in late May. Through the summer months, the Committee on Quackery, staff and other appropriate individuals of the Society have been working with PMS legal counsel to review file documents and prepare necessary interrogatories. Since this is a class action anti-trust suit, we are anticipating a long and difficult struggle which could conceivably run in excess of two years. Estimated legal expenses to defend against the suit will range from $75,000 to $100,000 per year. The Board of Trustees and Councilors has approved the use of monies in the Quackery Defense Fund to defray as much of this cost as possible. The fund at the present time totals approximately $60,000.

A. Implementation of AMA Committee on Quackery

In 1975, several state delegations, PMS included, submitted resolutions to the AMA House of Delegates recommending reactivation of the AMA Committee on Quackery. The AMA House acted favorably on the recommendation, but administratively it was never carried out. Since there are many forms of quackery existing in this country, the PMS Committee on Quackery believes it is imperative that such a national committee be formed.

Recommendation

The Board of Trustees recommends that the House of Delegates give consideration as to whether or not the following resolution which calls for the activation of an AMA committee on quackery be introduced at the AMA Clinical Session in the fall.

WHEREAS, in December 1975, the AMA House of Delegates recommended re-activation of an AMA Committee to fight all types of quackery; and

WHEREAS, this recommendation was not implemented by the AMA administration; and

WHEREAS, the problem of quackery continues to grow (as evidenced by the problem of laetrile); and

WHEREAS, there is currently no national body which is fighting all types of quackery; therefore be it

RESOLVED, that within 90 days following the passage of this resolution, the AMA activate a committee on quackery whose mission is to oppose all types of health fraud deception.

B. Establishment of National Quackery Defense Fund

In line with the recommendation to reactivate the AMA's Committee on Quackery, it has been suggested that a nationwide quackery defense fund be developed similar to the fund established by PMS. In view of the litigation the AMA has been involved in with the Church of Scientology and now chiropractic, it is believed that such a fund would be extremely useful.

Recommendation

The Board of Trustees and Councilors recommends that the House of Delegates give consideration as to whether or not a resolution should be introduced at the AMA Clinical Session in the fall recommending that the AMA establish a nationwide quackery defense fund supported by voluntary contributions from physicians.

C. Re-establishment of AMA Investigation Department

There also has been discussion on the need for an AMA Investigation Department. Many physicians will recall that prior to the AMA's budget crunch a few years ago, such a department existed. The Committee on Quackery believes there is a tremendous need for such a department on the national level. This department could greatly assist committees such as ours in the investigation of health fraud.

Recommendation

The Board of Trustees recommends that the House of Delegates give consideration as to whether or not the following resolution calling for the re-establishment of the AMA Department of Investigation be introduced to the fall AMA Clinical Session.

WHEREAS, the problem of quackery continues to grow; and

WHEREAS, there is currently no national body involved in the investigation of health fraud; and

WHEREAS, a force of this type is badly needed to protect the public from such fraud; therefore be it

RESOLVED, that the AMA Department of Investigation be re-established.

Summary of Legal Expenses

The trustee of the Twelfth Councilor District suggested that a listing of legal costs be presented to the House of Delegates. The Board of Trustees concurs that it would be interesting for the House of Delegates to see a breakdown of legal expenses, and therefore presents the figures listed below which cover the period from 1968 to the present:

Legal Expenses

Year	General Legal Expenses	Medical Defense	Malpractice	PMSLIC	Quackery
1968	$18,869	$ 2,322	...	...	...
1969	26,471	12,716	...	...	...
1970	21,780	14,806	...	...	...
1971	25,830	14,228	...	...	...
1972	30,219	732	...	...	...
1973	35,808	8,605	...	...	...
1974	40,749	3,437	...	...	...
1975	48,756	2,737	$103,470	...	...
1976	77,940	22,635	117,892	$21,030	$ 707
Jan. to July 31, 1977	49,344	24,314	89,778	5,111	13,690

Expert Witness

The PMS Board of Trustees on November 10, 1976 voted to cooperate with law enforcement officials by supplying expert witnesses to the prosecution in cases of violation of the Controlled Substances Act, Act 340 of 1974.

There has been considerable publicity over the past several months concerning a few physicians who are violating the law and providing a source of illegal drugs. Specifically, the physicians are violating Section 13, Clause 14 of Act 64 as amended by Act 340, which prohibits: "the administration, dispensing, delivery, gift or prescription of any controlled substance by any practitioner or professional assistant under the practitioner's direction and supervision unless done (1) in good faith in the course of his professional practice; (2) within the scope of the patient relationship; (3) in accordance with treatment principles accepted by a responsible segment of the medical profession."

Expert witnesses are needed to testify, not against the defendant, but to the standards of acceptable "treatment principles."

Following Board action, the county medical and state specialty societies were contacted by PMS to encourage their support and assistance in providing witnesses as requested by the various law officials on the local level.

Since the mechanism has been in place, several requests have been handled through PMS and several others directly through the local societies. Dr. Kelly highlighted the Society's action in a speech before the Pittsburgh Press Club in August.

Status of Argonaut's Suit

During the summer months, discovery proceedings in Argonaut's $25 million suit against the Pennsylvania Medical Society continued. Depositions of both PMS and Argonaut representatives were secured and it appeared that the case would be scheduled for trial in the Eastern District Federal Court in the fall of 1977.

However, during the months of August and September 1977, settlement discussions between PMS, Argonaut, and Frank B. Hall occurred. While an attempt to reach a settlement in August did not materialize, a similar agreement was approved by the Board of Trustees at a special meeting on September 13, 1977, through which the PMS, Argonaut, and Frank B. Hall agreed to eliminate all existing suits based on the Society's ability to activate the Pennsylvania Medical Society Liability Insurance Company (PMSLIC) by January 1, 1978 or at the very latest April 1, 1978.

The settlement agreement is a complicated instrument containing a variety of protective mechanisms for all parties. From Argonaut's standpoint, its legal actions against the Pennsylvania Medical Society will not be jeopardized should the Society be unable to proceed with the activation of PMSLIC. On the other hand, should the Pennsylvania Medical Society's efforts to secure sufficient capitalization to proceed with marketing insurance through PMSLIC fail, the Society is entitled to retreat from the agreement and all things would essentially revert back to the situation as it was prior to the settlement discussions.

As of the writing of this report, the Society is actively engaged in efforts to promote and capitalize the Society's liability insurance company for the benefit of all members of the Pennsylvania Medical Society.

Results of PMS Intervention in Rate Increase Hearings for Argonaut, ISO, and JUA

Since the Board of Trustees' initial report to the House of Delegates was prepared, there has been considerable activity in the area of professional liability insurance rate increase requests. Petitions to intervene in Argonaut, Joint Underwriting Association (JUA), and Insurance Services Office (ISO) hearings were approved by the Pennsylvania Insurance Department in behalf of all members of the Pennsylvania Medical Society.

As was previously reported, the Argonaut Insurance Company early this year had requested a rate increase in the amount of 70 percent. Following 16 days of official hearings, the second longest hearing in Insurance Department history, the Argonaut request was rejected. However, an increase in the amount of 23.6 percent was refiled and approved per negotiations between Argonaut and the Insurance Department. That increase incorporated revised class relativities and territories as approved by the House of Delegates at its Special Session in April 1977. The net saving to Argonaut policyholders was in the amount of $6 million. This result was due in large measure to the aggressive intervention by PMS actuaries and legal counsel.

The Joint Underwriting Association (JUA) rate filing for approximately 45 percent increase was also rejected. Instead, the Insurance Department agreed to a rate level identical to that which had recently been approved for Argonaut—including the changes in class relativities and territories.

The Insurance Services Office (ISO) has a request pending for use of higher increased limits factors in Pennsylvania. These factors are multiples which are used to determine rates of $100,000/$300,000 when applied to the base rates of $25,000/$75,000. PMS testimony at the hearing asserted that the current increased limits factors being used by the ISO were adequate, if not excessive. The ISO request, if granted, would amount to increased premiums of 15-17 percent for those companies subscribing to the ISO. Final briefs on this issue are due in mid-September and a decision by the Insurance Department should be forthcoming some time in October.

August 1977 Board Actions

At its August 1977 meeting, the Board of Trustees took action on a number of items which are of interest to the House of Delegates

but which require no specific House action. The Board takes this opportunity to inform the House of Delegates of some of the major actions taken at the meeting. Items which require House action will be in additional supplemental reports. The actions are as follows:

1. Approved the recommendation of the Council on Education and Science that PMS endorse the hypertension screening program of the Pennsylvania Department of Health.

2. Approved the establishment of a PMS credit union for members, their families, and employees, and that PMS provide bookkeeping and staff services as necessary, in addition to necessary promotion and literature during the first year of operation with an initial budget of $500.

3. The Board reaffirmed its policy of support services to specialty societies, including expansion of the field contact service to include services to all specialty societies not currently utilizing PMS administrative support services.

4. Approved the institution of a flood loan program to assist physicians in the Johnstown area. To date, 18 doctors have taken advantage of the flood loan program, and outstanding loans total $126,000.

Respectfully submitted,
John V. Blady, M.D.
David W. Clare, M.D.
Donald R. Cooper, M.D.
Kenneth L. Cooper, M.D.
Leroy A. Gehris, M.D.
Raymond C. Grandon, M.D.
Donald E. Harrop, M.D.
Richard L. Huber, M.D.
David J. Keck, M.D.
William J. Kelly, M.D.
John B. Lovette, M.D.
David S. Masland, M.D.
Carol N. Maurer, M.D.
Orlo G. McCoy, M.D.
Joseph M. Stowell, M.D.
D. Ernest Witt, M.D.
G. Winfield Yarnall, M.D.
William C. Ryan, M.D., Vice Chairman
George A. Rowland, M.D., Chairman

Appendix F

Supplemental Report B
Board of Trustees and Councilors
Society Restructure

On September 14, 1977, at a special meeting of the Board of Trustees and Councilors, a report was considered from the Ad Hoc Committee to Study Society Structure. As mentioned in the Annual Report of the Board of Trustees (see Official Reports Booklet), the Ad Hoc Committee to Study Society Structure was instructed to review present organizational structure and make recommendations to eliminate duplication of activities.

We feel that there should be no more committees than are necessary to accomplish the work of this Society. In order to respond to the often fast-changing social and economic climate that surrounds the practice of medicine, these units should be examined from time to time to see if they're still relevant or whether it might be advisable to shift the work to some other unit which might be working on related problems. As far as possible, we believe activities should fall under the direct supervision of an administrative council.

Therefore, the Board of Trustees and Councilors requests the House of Delegates to consider the following administrative structural changes.

There are currently two special committees of the House of Delegates in existence. In 1963, the House of Delegates approved a recommendation of the Board of Trustees that the House create a committee on medicine and religion. In 1974 the charge was expanded to include bioethics. The Board of Trustees still believes that these areas need to be addressed and feels that these responsibilities should be assigned to one of our existing councils. **The Board recommends to the House that the Committee on Medicine, Religion and Bioethics be eliminated and that a new commission be created under the Council on Education and Science charged with the present committee's functions.**

The second special committee of the House is the Committee to Study Relations between Medicine and Osteopathy. This Committee was created in 1961 to study future relations between medicine and osteopathy including the possibility of merger of the two. As you are all aware, that examination has long since run its course. This Committee has been inactive for years and has been serving on a standby basis only since 1974. There is an ongoing relationship between medicine and osteopathy carried on by all the administrative councils depending on the area in question. Overall liaison is coordinated by the Board of Trustees. **The Board of Trustees and Councilors recommends to the House of Delegates that the Committee to Study Relationships between Medicine and Osteopathy be eliminated.**

The Committee on Discipline is a standing committee of the Society and one that has been relatively inactive. It is a body that exists outside the normal disciplinary proceedings of the Society as provided for in our Bylaws. The Bylaws state that the Committee on Discipline should not conflict or supersede the provisions for the regular disciplinary and appeal process as contained in Chapter 13 of the Bylaws. The Board would like to stress that this recommendation for elimination should not be interpreted as a de-emphasis on medical discipline by our Society. A complete re-examination of the entire disciplinary procedure, to be coordinated by the Secretary's office, is planned by the Board of Trustees for the near future. Despite this concern in the area of discipline, the Board does not feel the committee should remain simply because it has a high priority term in its title. **Therefore, the Board of Trustees and Councilors recommends to the House of Delegates that the Committee on Discipline be eliminated and that its duties be carried out on an ad hoc basis as assigned by the Board of Trustees and Councilors.**

As a point of information, the annual report of the Board of Trustees and Councilors recommends the elimination of the Committee on Objectives. In a related matter, it is noted that the annual report of the Committee on Relationships with Allied Professions contains a recommendation for its own elimination.

The Board spent considerable time reviewing the recommendations of the Ad Hoc Committee concerning the major accountabilities now assigned to the Society's councils. It was noted that the responsibilities of the various councils as outlined in the Bylaws of the Society sometimes differ with the current list of council accountabilities. The Board feels that accountabilities change rapidly and that no attempt should be made to detail in the Bylaws a comprehensive list of accountabilities for each council, thereby enabling the Society to have the flexibility to deal with issues in a more responsive way. It was also the feeling of the Board that the names of the councils should describe as clearly as possible the charges assigned to them by the House of Delegates and the Board of Trustees and Councilors.

The Board of Trustees suggests the following changes with regard to the Society's councils:

The Board feels that the name "Council on Legislative Activity" would more accurately describe the current function of the Council on Governmental Relations. **The Board therefore recommends that the Council name be changed from Council on Governmental Relations to Council on Legislative Activity.**

In regard to the Council on Medical Service, there is a general

feeling that its name does not accurately describe its responsibilities. Its responsibilities generally deal with the socio-economic aspect of medicine, not with medical services, per se. **The Board of Trustees and Councilors recommends to the House of Delegates that the name of the Council on Medical Service be changed to the Council on Socio-Economic Affairs.**

A special note was made of the long list of the high priority accountabilities currently assigned to the Council on Medical Service. These include such areas as quality of medical care, long-term care, health planning, professional liability insurance, relations with third party payers, and health care costs. The Board notes that under existing structure, the Council on Medical Service is the logical area for the formal assignment of the overall responsibility for developing strong relations with hospital medical staffs and providing service to meet their specific needs. This is an area of certain rapid expansion and is one that will need a high degree of Society attention. When responsibilities and accountabilities reach this magnitude, thought must be given as to whether one administrative unit can deal with so many varied topics effectively.

The Board of Trustees is not recommending the specific creation of an additional council at this time, but is simply alerting the House to a possible area of difficulty in the near future. The Board of Trustees feels it should be properly equipped to assign all added responsibilities as they occur.

This need for responsive flexibility by the Board of Trustees is illustrated by the current status of the Pennsylvania Medical Care Foundation. As you are aware, the question of continued PMS funding of the Pennsylvania Medical Care Foundation is before the House for consideration. The Board, in the past, has been assigning certain responsibilities to the Foundation. Should the Foundation not be funded, these responsibilities would have to be re-assigned to an existing body of this Society.

The Board will carry out the wishes of the House and assure that all responsibilities are appropriately assigned. In view of rapidly changing priorities, the Board encourages the House to make the Bylaws an instrument to meet the demands placed on PMS with respect to the number of administrative councils and their specific accountabilities.

The Board of Trustees and Councilors recommends that the House of Delegates change the section of the Bylaws dealing with administrative councils so as not to limit the specific number of administrative councils and their accountabilities. In addition, the Board requests authorization to create appropriate administrative councils as needed, subject to review by the House of Delegates.

To that end, the Board of Trustees and Councilors suggests the following Bylaws change:

Chapter XIV, Section 4, Administrative Councils, to be amended as follows:

The administrative councils shall conduct all of the activities and business of the Society, except as otherwise provided by the Constitution and Bylaws. This Society shall have administrative councils as deemed necessary to carry out the business of the Society. The final determination thereof shall be the responsibility of the Board of Trustees and Councilors, subject to review by the House of Delegates.

Each administrative council shall report directly to the Board of Trustees and Councilors and annually to the House of Delegates.

Respectfully submitted,
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Raymond C. Grandon, M.D.
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William C. Ryan, M.D., Vice Chairman
George A. Rowland, M.D., Chairman

Appendix G

Supplemental Report C
Board of Trustees and Councilors
Relationship—PMS and PBS (Pennsylvania Blue Shield)

At the special September 14, 1977 meeting, the Board of Trustees reviewed a series of recommendations that resulted from a study conducted by PMS legal counsel in which they examined the relationship between PMS and PBS. The recommendations were designed to minimize the exposure of PMS to anti-trust liability as a result of those relationships.

Historically the ties between PMS and PBS have been many. Blue Shield, because of the nature of its business, has a significant impact on physicians' fees in Pennsylvania due to the large number of subscribers with Blue Shield coverage. PBS is governed by a corporation, and from that corporate membership, the Board is elected. These two bodies set the basic policy for the operation of PBS.

There is physician involvement in the Blue Shield corporation and its Board. No one could argue the value of physician input into the policymaking process of any health care insurance program; qualified physician input is needed and should be provided for. Legal counsel pointed out to the Board that the Federal Trade Commission (FTC) is concerned that organized medicine not control that input.

There are two basic ways for a participating physician to become a member of the Blue Shield corporation. The first is to be elected by his peers. Each participating physician is entitled to make nominations for election to the Blue Shield corporation. Each year Blue Shield solicits nominations from the various county medical societies for the names of physicians that might be interested in running. The county medical societies then forward the names to the Blue Shield nominating committee and the ballots are drawn. Even though the medical societies are not intended to be an exclusive source, county medical societies provide the majority of the names for the corporate membership election ballot.

The second way for a physician to gain a position in the corporation is to be appointed as one of the members-at-large to the corporate membership of Pennsylvania Blue Shield. PMS is presently entitled to appoint a total of fourteen. The member-at-large positions are provided for in the Blue Shield Bylaws and are based on a one member-at-large for each 1,000 participating providers, or a fraction thereof, in a particular category, e.g., physicians, dentists, etc.

The Board of Blue Shield is charged with implementing the policies of the corporation. The Blue Shield Board is elected from the corporation.

Recent decisions by the United States Supreme Court have resolved any doubts concerning the applicability of the anti-trust laws to the learned professions. The courts have determined that the anti-trust laws apply to the practice of medicine, and that they particularly apply when the conduct under scrutiny fixes or stabilizes prices. Several courts have held health care pre-payment

plans like Pennsylvania Blue Shield immune from anti-trust enforcement because they are within the scope of the McCarran Ferguson Act which exempts from the anti-trust laws the business of insurance to the extent that it is regulated by the state. The same courts have refused to extend that exemption to the medical societies that deal with insurers. In fact, the interaction of medical societies and Blue Shield Plans is the subject of a specific investigation undertaken by the Federal Trade Commission which is reportedly concerned with the Blue Shield plans' control over prevailing fees. In short, we can expect increasing scrutiny over all PMS activities, and particularly its relationship with Pennsylvania Blue Shield.

Because of Blue Shield's unique role as an insurance carrier, they are exposed to little danger as they deal with such issues as fee determination, etc. The Pennsylvania Medical Society also is in no danger as long as the Blue Shield corporation and their Board are independent of PMS.

The Board would like to make it very clear to the House that the simple threat of anti-trust litigation should not in itself dictate our policy, but, on the other hand, we should be aware of all possible consequences of our activities and avoid, where possible, unnecessary complications.

In view of the results of the recent study conducted by legal counsel, the Board would like the House of Delegates to consider the following:

The Board of Trustees recommends that PMS adopt the policy that no one in a leadership position with PMS, i.e., trustee, officer, etc., should serve on the Blue Shield Board of Directors.

The Board would also like the House of Delegates to decide whether or not the PMS Board of Trustees should continue to make appointments of the members-at-large to the corporate membership of Pennsylvania Blue Shield.

In addition the Board would like the House of Delegates to decide whether or not Blue Shield should be encouraged to find an alternative method of soliciting names for possible election to the corporate membership other than direct solicitation to the county medical societies.

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George A. Rowland, M.D., Chairman

Appendix H

Supplemental Report D
Board of Trustees and Councilors
Pennsylvania Medical Society Liability Insurance Company (PMSLIC)

Most of you will recall that at its July, 1976 Special Session, the House of Delegates authorized the establishment of a physician-owned and operated professional liability insurance company. That facility, hereinafter referred to as PMSLIC, was formed but held in reserve while Argonaut continued to perform satisfactorily under the contract which runs through May 31, 1979 between PMS, Frank B. Hall & Co., Inc. of Pennsylvania, and the Argonaut.

Much has transpired in the intervening fifteen months in this area. At the 1976 Annual Session in Philadelphia, the House of Delegates addressed the issue of capitalizing PMSLIC if it became necessary to activate the company. (This issue will be discussed in greater detail later in this report.) During this period, the Society has expended a huge amount of money in protecting the best interests of its members in their dealings with Argonaut, in addition to the fact that a disproportionate amount of time has been required by Society officers and staff to the detriment of many other extremely important Society concerns. As an example, Argonaut filed for a 70% rate increase in January of 1977. The hearing which was scheduled to last three days actually covered sixteen full days spread over several months. The time and dollar commitment to that hearing far surpassed anyone's expectation. And since Argonaut has not had what it considered appropriate rates since late in 1975, it is certain that continued business in Pennsylvania would guarantee repeated rate filings until the desired rate level was reached or the expiration date of the contract passed.

Additionally, Argonaut's $25 million suit against the Society continued through the discovery process. Depositions and Document Production have been costly in terms of time and money and legal counsel costs are expected to be in the $100,000 range should the matter reach trial.

These are among the reasons why the Board of Trustees and Councilors authorized discussions with Argonaut late this summer through which an agreement could be reached that would release Argonaut from the remainder of the tripartite contract—substituting PMSLIC in its place—and terminating all outstanding litigation. A settlement agreement was developed which was agreeable to all three parties and at a special meeting on September 13, 1977 the Board of Trustees and Councilors determined to go forward with PMSLIC. (A copy of the settlement agreement signed by all parties is attached.) Also, in a letter dated October 12, 1977, Pennsylvania Insurance Commissioner William J. Sheppard has indicated his department's approval.

In addition to endorsing the settlement agreement, the Board of Trustees and Councilors authorized implementation of a $250 mandatory assessment for every member of the Pennsylvania Medical Society (with a proportionate reduction for other dues-paying members) and a schedule of selective assessments for those PMS members who seek insurance from PMSLIC. The adopted assessments differ from the assessments authorized by the PMS House of Delegates in September of 1976. That resolution stated:

RESOLVED, That there is hereby levied, assessed and imposed a mandatory assessment upon all members of this Society in the amount of Five Hundred Dollars ($500.) per each active member and a proportionate amount in accordance with the amount of dues paid by all other classifications of members, payable only upon authorization of, and in accordance with, terms as to payment to be adopted by resolutions of the Board of Trustees and Councilors, enforceable by termination of membership in this Society upon non-payment when due; and

RESOLVED FURTHER, That any member of this Society who terminates such membership and again applies to become a member of this Society shall be fully liable for the assessment imposed hereby; provided however, that the penalty of termination of membership for non-payment of this assessment may, upon recommendation of such member's Component County Medical Society and upon review and approval by the Board of Trustees and Councilors of this Society, be waived upon showing special cir-

cumstances such as, and without limitation, cessation of practice by reason of health, total removal of practice from Pennsylvania, etc., and

RESOLVED FURTHER, That there is hereby levied, assessed and imposed an additional mandatory assessment in the amount of Five Hundred Dollars ($500.) per member payable only upon authorization of, and in accordance with, terms as to payment to be adopted by resolution of the Board of Trustees and Councilors by members of this Society who apply to the Company for insurance; provided, however, that upon rejection of an application for insurance to the Company by a member of this Society, the selective assessment levied upon applicants for insurance shall be returned to the applicant-member; and

RESOLVED FURTHER, That appropriate officers of this Society be and they hereby are authorized to take any and all necessary and proper acts to give effect to this resolution and to contribute on behalf of the Society to the Company as policyholders' surplus any and all sums raised pursuant to the mandatory uniform and selective assessments imposed hereby; and

RESOLVED FURTHER, That it be clear that this resolution is intended to be implemented in case the Argonaut Insurance Company does not continue its contractual responsibilities with Pennsylvania Medical Society; and

RESOLVED FURTHER, That the authority to impose the mandatory assessment on the membership of the Pennsylvania Medical Society will expire unless this authority is reaffirmed by the House of Delegates at the 1977 Annual Meeting.

The Board of Trustees has been advised that it had the authority to adopt different assessments from those adopted last year by the House of Delegates. This advice was based primarily on the fact that the original authorizing resolution (quoted fully above) was to be implemented if Argonaut "does not continue its contractual responsibilities with the" PMS. Since this event has not occurred, it was reasoned that the action of the House of Delegates did not come into operation. Thus the Board of Trustees adopted a new plan which reduces the mandatory all-member assessment to $250. In reviewing the situation, the Board of Trustees felt that a $500 mandatory assessment was excessive and it was felt that the majority of the surplus should come from policy holders, the practice followed by most other physician-owned companies. To make the selective assessment as equitable as possible, the Board determined to graduate the assessment according to Risk Class.

It is, however, the view of the PMS Board of Trustees that such a decision must be ratified and approved by the House of Delegates. The assessments, as modified, have been sent to all members of the PMS and in fact, as of October 20, 1977, $1,006,776 has been collected by the PMS. However, if the House of Delegates disapproves, it seems certain that the necessary fund raising to build up a sufficient amount of policyholders' surplus of PMSLIC would fail. Therefore, if the House of Delegates rejects the following resolution or a similar substitute, fund-raising activities will be abandoned.

The Settlement Agreement with the Argonaut Insurance Company provides for closing on or before December 1, 1977. If sufficient funding is not realized by then, the Agreement provides that it will not take place and the Pennsylvania Medical Society and Argonaut will return to the prior status in the several law suits as if the Settlement Agreement had never been signed.

Accordingly, the Board of Trustees and Councilors recommends that the House of Delegates approve the following resolution:

RESOLVED, That it is hereby levied, assessed and imposed a mandatory assessment upon all members of this Society in the amount of Two Hundred Fifty ($250) per each active member and a proportionate amount in accordance with the amount of dues paid by all other classifications of members, payable on or before November 15, 1977, and enforceable by penalty of termination of membership pursuant to this Society's Bylaws upon non-payment when due; and

RESOLVED FURTHER, That it is hereby levied, assessed and imposed that an additional assessment in the following amounts for the following members who apply to the Pennsylvania Medical Society Liability Insurance Company (Company) for insurance, provided, however, that upon rejection of application for insurance to the Company by a member of this Society, the selective assessment levied on the applicant for insurance shall be returned in full to the applicant-member:

Class 1	$ 385
Class 2	$ 710
Class 3	$1,100
Class 4	$2,290
Class 5	$2,625

RESOLVED FURTHER, That appropriate officers of this Society be and they are authorized to take any and all necessary and proper acts to give effect to this resolution and to invest on behalf of this Society sums in the subordinated notes of the Company necessary for the Company to begin business, including but not limited to any portion of the sums raised pursuant to the mandatory uniform and selective assessments imposed hereby; and if such sums are not sufficient for the Company to begin business if invested in subordinated notes, then the appropriate officers are authorized to refund such sums to the payors.

The Board of Trustees and Councilors is mindful of the expression by the House of Delegates at the Special Session in July of 1976 that if legal, PMSLIC coverage be strictly limited to PMS members. Philosophically, the Board of Trustees and Councilors agrees with that position. However, the House of Delegates should recognize that there are certain considerations that may bear on this issue in the future:

(1) The Pennsylvania Insurance Department may require PMSLIC to extend coverage to non-PMS members;

(2) There may be anti-trust or restraint of trade implications.

Even if it develops that non-PMS members could be entitled to PMSLIC coverage, the Board of Trustees intends that it will always be more advantageous for PMSLIC insureds to maintain PMS membership.

Since the September 13 decision to activate PMSLIC, a great deal of work has been accomplished. Society officers and staff are attending meetings of county medical societies and hospital medical staffs in an effort to answer as many questions as possible; legal and actuarial work is proceeding; the PMSLIC Board of Directors or its Executive Board is meeting weekly to prioritize and resolve problems that will enable an orderly transition of business from Argonaut to PMSLIC on January 1, 1978. Promotional and educational information is currently being developed, some of which will be available to delegates in Lancaster on October 25.

While a tremendous amount of work remains, much has been accomplished in little more than one month. There are currently some fifteen physician-owned and operated professional liability insurance companies functioning in this nation and their vital signs are very good at this point in time. With your support, PMSLIC will join these ranks and we are confident that this will be a company of which all PMS members can be very proud.

Respectfully submitted,
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Appendix I

Supplemental Report E
Board of Trustees and Councilors
Implementation of 1976 House of Delegates
Recommendation 10.05

At the 1976 meeting of the House of Delegates, the following recommendation was contained in the address of the President of the Pennsylvania Medical Care Foundation pertaining to data management:

The Pennsylvania Medical Society should officially address the medical data issue and consider developing the capability to handle data generated by the professional activities of physicians to best serve their interests and needs of the physicians of the Commonwealth, including the needs demanded by peer review of the necessity, appropriateness, and quality of services which physicians either provide or prescribe. Such a project could also include in the assessment of the administrative data needs of the Pennsylvania Medical Society (membership records, mailing lists, inventory systems for the Cooperative, record systems for the captive insurance company, etc.).

As reported earlier in the annual report to the Board of Trustees and Councilors, a recommendation was approved to retain the services of a consulting firm to study the Society's data processing needs. The data process consulting firm of Auerbach Associates, Inc. (AAI), 121 North Broad Street, Philadelphia, Pennsylvania, was retained. Mr. Robert L. Getis, Project Manager, was assigned by Auerbach Associates as the project coordinator.

Currently, the Pennsylvania Medical Society uses a local computer service bureau to support a few key, high-volume application areas. The AAI study addressed the following two main areas: (1) the feasibility of computer support in other application areas, and (2) the feasibility of acquiring a computer for in-house operation.

The report from AAI addressed those two questions. The study considered current and future requirements and the potential costs and benefits involved in alternative approaches. It was a broad, management level study, not a detailed requirement study, and was aimed at providing overall guidance to the Society as to the feasibility of approaches.

Based upon the analysis of current and future PMS data systems, AAI concluded that computer processing is indeed an important and economically sound aspect of the Society's operation. The primary conclusions resulting from the study are addressed to the feasibility of computer applications, whether or not PMS acquires a computer.

According to the study, **it is clear that in-house computing offers no immediate cost benefits to PMS. In fact, costs would be certain to increase. Thus, acquisition of a computer cannot be justified on economic grounds.**

There are, however, indirect benefits associated with operation of the Society's own computer. Several such benefits have been identified during the course of the study and the Society should consider these in making its computer decision. Potential indirect benefits include:

(a) More responsive processing service through in-house computing;

(b) More responsive systems development;

(c) Improved PMS familiarity with modern technology, greater awareness of computing capabilities and, as a result, a more progressive management posture;

(d) Enhanced image of the Society on the part of the members;

(e) Improved ability to take on responsibility for tasks and services to members and affiliated organizations;

(f) Possible development of a springboard for movement into major socio-economic data systems. This would facilitate the assertion by the membership that it should retain responsibility for its own data;

(g) A stronger position with regard to control of health data systems by the medical profession.

The Society may determine that these benefits listed above justify the additional cost of in-house computing.

AAI recommended that PMS expand and augment its data processing activities. On economic grounds, AAI advises against computer acquisition, but the Society may determine that the additional cost is justified by the indirect benefits that would be realized.

In AAI's judgment, the areas justifying automation currently are limited to: lists, dues, CME (continuing medical education), and Co-op.

Looking into the future, we anticipate that student loans may achieve significant volume to warrant automation, the PMS credit union will require automation, and there is planned automation of Word Processing and precomposition processing. Other applications appear marginal or less.

After reviewing the entire Auerbach study report, the Board of Trustees concurred with Auerbach Associates' recommendation that the Society not buy its own computer at this time and instead direct our efforts into more sophisticated system development in order to aid and streamline our operations where feasible.

The Board will continue to monitor this situation and will keep the House informed of any progress in this area.

Respectfully submitted,
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Appendix J

Supplemental Report F
Board of Trustees and Councilors
Establishment of Medical School Section

The Board of Trustees and Councilors has reviewed a report from the Council on Professional Relations and Services which advocates the establishment of a medical school section in conjunction with the PMS House of Delegates. In support of that recommendation, the Council noted that the AMA had sponsored its first meeting of the medical school section in June with successful

results. The AMA is now requesting that state societies provide a similar forum for the leaders of medical schools in an effort to improve communications between medical school deans, faculty and administrators, and organized medicine.

The Board of Trustees agrees that the establishment of a medical school section in Pennsylvania would indeed increase communications between the Society and teaching institutions. Such action would also aid in membership recruitment efforts. The Board of Trustees also concurs with the suggested implementation plan of the Council on Professional Relations and Services. **Therefore, the Board of Trustees and Councilors recommends that the House of Delegates approve the establishment of a medical school section in conjunction with the PMS House of Delegates.**

In addition, the Board of Trustees recommends the following stipulations contingent upon approval of the above recommendation: that the section be named "the section on medical schools"; that membership in this section shall include deans of Pennsylvania medical schools provided he/she is an active member of the Pennsylvania Medical Society. In the event the dean is not an active member of the Society, the dean may designate a representative who is; membership shall include up to five members of administration or faculty of each Pennsylvania medical school, designated by the dean of the school, who are active members of the Pennsylvania Medical Society; the section will elect a chairman, vice chairman, secretary, delegate and alternate delegate to the Pennsylvania Medical Society House of Delegates. The organization and structure of the section would include, but not be limited to, a business meeting which would be held in conjunction with the PMS House of Delegates Session, and there should be a governing council of the section to consist of the officers and two members elected by the section membership at the business meeting of the section. The cost incurred by the participating members of the section should not be a responsibility of the Pennsylvania Medical Society.

Establishment of a Resident Physician Section

The Board of Trustees reviewed a resolution submitted by the Council on Professional Relations and Services which recommends establishment of a formal resident physician section.

The Board of Trustees feels that there is merit in establishing a permanent resident physician section and recommends adoption of the following resolution:

WHEREAS, Resident physicians in Pennsylvania have a genuine vested interest in the business of organized medicine within this state and nation; and

WHEREAS, The need for solidarity within the medical profession is ever-increasing as numerous special interest groups and governmental agencies continue the assault on the physician/patient relationship; and

WHEREAS, The AMA formed a resident physician section in 1972 giving House officers voting position on all major AMA policy boards and a voting delegate to the House of Delegates; and

WHEREAS, AMA Executive Vice President, James H. Sammons, M.D., has stated publicly that active participation by residents is vital to the future of the federation and the solidarity of the medical profession; therefore, be it

RESOLVED, That the Pennsylvania Medical Society form a resident physician section to provide a forum within the State Society for the exchange of information among resident member physicians in training and their more senior colleagues; and be it further

RESOLVED, That the governing committee of the section be formed to meet and carry out the function of the section between annual meetings and that this committee be properly funded; and be it further

RESOLVED, That the State Society will include House officers in the decision or policymaking process affecting all physicians in the state and shall include, but not be limited to, representation in the House of Delegates; and be it further

RESOLVED, That the Pennsylvania Medical Society find it in the best interest of the Society to include the appropriate number of House officers in its delegation to both the annual and interim resident physician section meetings held in conjunction with the AMA annual and interim meetings.

(Fiscal note: adoption of this resolution would require funds in the amount of approximately $3,000 for the governing committee and an additional $8,000-$10,000 to sponsor six House officers to attend both the annual and interim meetings.)

Annual Session Date Change

The 1977 annual report of the Board of Trustees and Councilors (see Official Reports Book) contains the recommendation that the 1982 annual business session be held at the Host Farm Resort Motel in Lancaster, November 1. When checking the calendar for future dates, it was discovered that Tuesday, November 2, 1982, is election day. **In view of this conflict, the Board of Trustees recommends that the House of Delegates consider a change in dates. The Board of Trustees and Councilors recommends to the House of Delegates that the 1982 Annual Business Session be held at the Host Farm Resort Motel, Lancaster, Pennsylvania, October 18-21.**

Pennsylvania Medical Care Foundation

The Board of Trustees and Councilors considered a report of the PMS Finance Committee concerning the 1978 proposed budget, specifically as it relates to proposed PMS funding of the Pennsylvania Medical Care Foundation in the amount of $96,160. The Finance Committee recommended and the Board of Trustees concurred that the funding for the Foundation should be included in the 1978 budget; however, there was some question as to the ultimate future of the Foundation.

After a lengthy discussion, the Board agreed that the funding for Foundation-related activities should remain a part of the proposed 1978 budget, but that the Foundation itself should be phased out over the coming year and its activities transferred to an administrative council of the Society. The Board will continue to study this proposed change and its ramifications and will be prepared to make specific recommendations to the 1978 House of Delegates. **Therefore, the Board of Trustees and Councilors recommends to the House of Delegates that over the next year the Pennsylvania Medical Care Foundation be phased out and its activities transferred in an orderly fashion to an administrative council and that the Board of Trustees be prepared to make final recommendations to the 1978 House of Delegates.**

Status of PMS Countersuits

At the direction of the Board of Trustees and Councilors, the Pennsylvania Medical Society's Ad Hoc Committee on Medical Malpractice Insurance, with the aid of legal counsel, has reviewed 55 medical malpractice suits against physicans. To date, two members of the Pennsylvania Medical Society have instituted actions for malicious use of civil process (countersuits). In one suit a complaint has been filed and the defendant attorneys have filed Preliminary Objections contending, among other things, that the countersuit does not properly lie because under Pennsylvania law an indispensable element of the tort of malicious use of civil process is that the physician must have been arrested or his property seized. This legal issue must be resolved by the Trial Court or Appellate Court before the case may be tried on the merits.

A second countersuit has been instituted by a member of the Pennsylvania Medical Society. Prior to filing a complaint, the physician has attempted to discover the defendant attorney's file

in an endeavor to establish whether the defendant attorney properly investigated the merits of the malpractice suit before it was instituted. The defendant has filed Preliminary Objections and the Trial Court or Appellate Courts must decide whether the defendant attorney's file is discoverable or protected by the doctrines of "privilege" or "work product" of counsel made in anticipation of litigation.

The Society will continue to review additional malpractice suits submitted by members who have been sued.

Respectfully submitted,
John V. Blady, M.D.
David W. Clare, M.D.
Donald R. Cooper, M.D.
Kenneth L. Cooper, M.D.
Leroy A. Gehris, M.D.
Raymond C. Grandon, M.D.
Donald E. Harrop, M.D.
Richard L. Huber, M.D.
David J. Keck, M.D.
William J. Kelly, M.D.
John B. Lovette, M.D.
David S. Masland, M.D.
Carol N. Maurer, M.D.
Orlo G. McCoy, M.D.
Joseph M. Stowell, M.D.
D. Ernest Witt, M.D.
G. Winfield Yarnall, M.D.
William C. Ryan, M.D., Vice Chairman
George A. Rowland, M.D., Chairman

Appendix K

Supplemental Report
Council On Governmental Relations

At this writing, the General Assembly has recessed after a hectic two months' exclusive battle with a state budget. During this time very little else has received their attention. They are scheduled to reconvene on September 26, just weeks before the House of Delegates opens its session. We think it is safe to assume that very little can be accomplished in other areas during that time, since the Legislature will have to begin immediately on the "rest of the budget"—the so-called non-preferred appropriations to schools, etc., and to taxes to raise the extra money to fund them.

We think it is important to note that since the convening of the General Assembly in January, very little, if any, work has been done in a host of areas, including several of interest to the Pennsylvania Medical Society. These areas include a code of ethics for legislators, tax reform at the local level, urban problems, rapid mass transit, review of mental health laws, development of the state's coal resources, comprehensive health planning, further solution in the medical malpractice area, review of the public employee bargaining law, environmental protection, consumerism and public utility control, "sunset" laws, the executive Department's regulatory authority, etc., etc.

Despite this lack of attention to many desperate areas, the Society will continue to push for attention to its legislative objectives, as follows:

Amendments to Act 111, the "Medical Malpractice Act":

Pennsylvania professional corporations to be permitted coverage under the Catastrophe Loss Fund;

Provide for a minimum three-year statute of limitations;

Limit payment for pain and suffering to "grievous impairment";

Provide that "punitive damages" be sent to the State Board of Medical Education and Licensure;

Provide for election of the patient of binding arbitration without appeal to the court;

Elimination of PSRO norms, standards and criteria;

Provide that "periodic payments" may be awarded by the court.

We will be introducing and supporting, at the suggestion of our House of Delegates, a so-called "Confidentiality of Health Care Information Act." This bill would tighten up availability of patient medical records. Its stated purpose is to "establish safeguards for maintaining the integrity of confidential health care information."

The Society has caused to be introduced S-233, which would amend the "Clinical Laboratory Act" to exclude "laboratories operated by a physician operated solely in connection with the diagnosis and treatment of his own patients."

The Society will be supporting S-586, which was introduced to give the State Board of Medical Education and Licensure authority to certify a physician's assistant's training and practice. This bill has passed the Senate and is before the House Committee on Health and Welfare.

We will also be supporting S-339, the measure to regulate the Commonwealth's ambulance services and require minimum standards for equipment and their operators. This bill has already passed the Senate and is before the House Transportation Committee.

We will be interested in amendments to the "Mental Health Procedures Act" (Act 143) designed to lessen the involvement of the courts into the treatment process.

We will be supporting legislation to change the definition of "still-born" from sixteen to twenty-eight weeks.

During the years the Council has spent a goodly amount of time during its meetings on the question of how to discipline physicians known to their colleagues to not be practicing good medicine for various reasons. At first we thought it would be possible to introduce legislation to give the Pennsylvania Medical Society this legal authority. Our legal counsel tells us this is not possible. Now we will turn our attention to other methods in order to get the State Board of Medical Education and Licensure the necessary authority to do the job.

Finally, there is a host of legislation which the Society has historically opposed. So far we have not gotten into these areas, but, as usual, this will occupy a great deal of our legislative time.

This year, to date, the Council has reported to the Board of Trustees at each of its meetings. It has reported on over fifty bills and resolutions that are before the Legislature (Attachment 1). Because, as we have noted earlier, of the budget impasse, very few have been acted upon, and it seems unlikely that those with any kind of a price tag will make it through this year.

Respectfully submitted,
R. William Alexander, M.D.
Thomas W. Bonekemper, M.D.
Frederick G. Brown, M.D.
Paul A. Cox, M.D.
Herbert Fellerman, M.D.
Philip E. Ingaglio, M.D.
Thomas J. Kardish, M.D.
Lawrence J. Mellon, Jr., M.D.
Peter L. Saras, M.D.
Mario Sebastianelli, M.D.
Bernard B. Zamostien, M.D.
Charles K. Zug, III, M.D.
David W. Clare, M.D., Board Representative
Michael P. Levis, M.D., Chairman

Attachment 1. Legislation of Interest to Medicine Introduced Into the 1977-78 Session of the Pennsylvania General Assembly as of October, 1977

Concerning	Bill No.	Explanation	Society's Position	Legislative Position
AGING	S-74	Creates a Department of Aging; transfers all aging services of government to new Department	No position	In Senate Committee
ALCOHOL AND DRUG ABUSE	S-978	Governor's Council on Drug & Alcohol Abuse to coordinate all programs	No position	In Senate Committee
AMBULANCES	S-339	Minimum standards for all state ambulance services	Support	Passed Senate; in House Committee
ANESTHESIA	S-1069	Equipment to be checked daily; fittings for different gasses to be dissimilar	Support Department of Labor and Industry's regulating installation of systems	In Senate Committee
CANCER	H-274	Hospitals to advise female patients of availability of Papanicolou test	Support giving information—no record keeping	Passed House; before Senate Committee
CANCER	H-1120	Would use cigarette tax for cancer research by State Health Department	Support, if Health Department administration is eliminated	In House Committee
CHIROPRACTORS	H-711	Would be included in Workmen's Compensation program	Oppose	Passed House with amendment to have patients see a physician first
CHIROPRACTORS	H-1238	Would place chiropractors in Blue Shield	Oppose	In House Committee
CLINICAL LABORATORIES	H-233	Would remove physicians' offices from definition in "Clinical Laboratory Act"	Support	In Senate Public Health & Welfare Committee
CONSUMERS	H-890 S-711	Would place consumers on licensing boards	No position; Medical Board already has one	Bills in Committees
DEATH CERTIFICATE	S-104	Cremation certificate only after notice to coroner	Support	In Senate Committee
DEATH CERTIFICATE	S-401	Nurse in charge at nursing home may sign death certificate	Oppose	In Senate Committee
DEVELOPMENTAL DISABILITIES	S-75	Creates a Department of Developmental Disabilities	Opposition	In Senate Committee
GHOST SURGERY	S-714 S-716	Requires patient to be informed of all present in operating room	Oppose	In Senate Committee
GOOD SAMARITAN LAW	H-978	Would amend law to include cardiac care units	Support	In House Committee
LAETRILE	S-901 H-1240	Would permit manufacture and sale in Pennsylvania	Oppose	Passed Senate; on House table
LUPUS RESEARCH	S-816	Would make a grant to Health Department to spend for research	Support research — not by Health Dept.	In Senate Committee
MALPRACTICE	S-921	Provides a limited liability category for semi-retired physicians under Act 111	Support principle	In Senate Committee
MALPRACTICE	S-679	Society-drafted bill to permit professional corporations to purchase coverage under Act 111	Support	Hearings held in Senate
MEDICAL ASSISTANCE	S-292	Departmental preauthorization for non-emergency procedures	Oppose	In Senate Committee
MEDICAL ASSISTANCE	H-254	Would require vendors to be reimbursed on cost-related basis	Support principle	In House Committee
MEDICAL PRACTICE	H-307	Requires a one-year general practice residency	Oppose	In House Committee
MENTAL HEALTH	H-394 H-395 S-1105	Corrective amendments to "Mental Health Procedures Act"	All under study by Pennsylvania Psychiatric Society	In Committee — hearings expected
MENTAL HEALTH COMMISSIONER	S-977	Removes requirement that he be a psychiatrist	Oppose	In Senate Committee
MENTAL RETARDATION	S-979	Changes provisions for care and placement of mentally retarded	No position	Hearings held in Senate
MOTORCYCLE HELMETS	S-550	Removes requirement in "Vehicle Code" that motorcyclists must wear helmets	Oppose	In Senate Committee
NEONATAL HYPERTHYROIDISM	H-922	Requires hospitals to test for neonatal hyperthyroidism	Under study	In House Committee
NEWBORN	S-958 S-959 S-960	Rights to medical treatment for premature infants; testing for genetic disease	Support principle	In Senate Committee
NURSING	S-684	Would have State Board of Nurse Examiners enforce continuing education	No opposition if done by their Association	In Senate Committee

Concerning	Bill No.	Explanation	Society's Position	Legislative Position
NURSING	H-137	Permits States Board of Nursing to examine any person who has served in the U. S. Military medical services	No position	In House Committee
ORTHOTISTS & PROSTHETISTS	S-340 S-341	These bills would license Orthotists and Prosthetists	Opposition	In Senate Committee
PHYSICIANS' ASSISTANTS	S-586	Would have State Board of Medical Education and Licensure certify physicians' assistants	Support	Passed Senate; in House Committee
PHYSICIANS' LIABILITY - PARA-MEDICS	S-752	Protects physicians when giving orders to emergency medical technicians	Support	In Senate Committee
PHYSICIANS' LICENSES	S-937	Bill designed to increase all state fees — would fix physicians' bi-annual renewals at $75.00	Oppose	Bill amended to eliminate and have fees set by State Board of Medical Education and Licensure
PHYSICAL THERAPY	H-410	Amends "Physical Therapy Act" to exclude athletic trainers	Oppose	In House Committee
PLANNING, HOSPITALS	H-1176	HAP-drafted "Health Care Planning and Resources Development Act"	No opposition since troublesome portions removed	In House Committee
PREMARITAL TESTING	H-273	Requires, in addition to present testing, tests for genetic diseases if physician feels it is necessary	No position	In House Committee
PRISONS	H-965	Would require physicians or nurses to be on duty at all times	Support with amend-ments to add physi-cians' assistants	In House Committee
PSYCHOLOGY	S-320	Include reimbursement for psy-chologists' services by insurance companies	Amend to restrict their services	Passed Senate — in House Committee
PUBLIC EATING PLACES	S-220	Would require all such establish-ments to have food removal devices	Opposition	In Senate Committee
PUBLIC WELFARE INVESTIGATIONS	S-753 H-923	Set up a special investigation unit in the Department of Public Welfare	No position	In Senate and House Committees
RUBELLA TESTING	H-1474	Females to have premarital rubella tests	Support	In House Committee
SALK VACCINE	H-1294	Advisory Health Board required to approve Salk Vaccine as substitute for Sabin Vaccine	Opposition	In House Committee
SMOKING PROHIBITED	H-989, 990 S-168	Smoking would be prohibited in hos-pitals and physicians' offices	No opposition with amendments that were added to S-168 to permit hospitals to designate areas	S-168 passed Senate
SPEECH AND HEAR-ING TECHNICIANS	S-86 & S-87	Creates a board to license speech and hearing technicians	Opposition	In Senate Committee
VEHICLE CODE	H-1171	Amends last year's codification; we are seeking repeal of Section 1518 which requires physicians to report patients' conditions	Support — with amendments	Passed House

Appendix L

Supplemental Report
Council on Medical Service
Commission on Professional Liability Insurance

Since the initial report of the Council on Medical Service which was included in the Official Reports Booklet (pages 67-74), the Commission has met two additional times.

On August 10, 1977 the Commission met primarily to review an Argonaut rate filing that would have increased rates approximately 17% for all classes. Review of Argonaut loss data in conjunction with several extraneous sources of data led Society actuaries to conclude that 17% was excessive and the Commission recommended that PMS not support the Argonaut filing.

Additionally, at its August meeting, the Commission preliminarily reviewed House Action 2.05 from the Special Session of the PMS House of Delegates held April 17, 1977. Action 2.05 reads as follows: "... further investigation be made of the effect of one territory for the State of Pennsylvania, of more than four territories in the state, and of possible regrouping of the presently proposed territories and that the Commission report back to the House of Delegates at its October, 1977 meeting."

Mr. Louis Roberts, PMS consulting actuary from the firm of Woodward & Fondiller, indicated his support of the Argonaut proposal for the current four-territorial breakdown in Pennsylvania which was approved by the House of Delegates in April, 1977. With respect to a statewide average rate, the Commission was concerned that it would be discriminatory against physicians in rural areas where fees paid are generally lower than those available in the more metropolitan areas. Consistent with that, was the argument that an average statewide rate would only be appropriate in a monopolistic market, in view of the fact that such a rate in a state where there is market competition would undoubtedly result in adverse selection in both risk classification and territory.

Mr. James Ross, Argonaut actuary, indicated that his company

believed that the four-territorial division which had been approved by the House of Delegates in April was the most equitable and further indicated that Argonaut was directed by the Pennsylvania Insurance Commissioner to use the current four territories in all future rate filings.

On October 19, 1977, the Commission on Professional Liability Insurance reviewed a Woodward & Fondiller report which studied rate differentials by county. The report was based on incurred loss experience for policy years 1971-1974 as of June 30, 1976, and compared data on demographic indicators and claims experience by county. Of particular interest to the Commission was a display which presented expected number of claims by county; actual number of claims by county; and the differential by county when compared to the county of Philadelphia. For example, the Commission noted that Chester County appeared to have had a significantly lower number of actual claims than could be expected for that county. Mr. Roberts pointed out, however, that the data for Chester County when tempered by use of a credibility formula, reduces the significance of the actual to expected claims data. Mr. Roberts indicated that greater credibility can be given to results when there has been a greater volume of claim experience for a given area. Because the better experience of Chester County was of a relatively small volume, the credibility of the indicators must be considered inconclusive.

The report suggested that seven distinct rating territories could be justified. A separate territory for Philadelphia, Montgomery, Delaware, Allegheny, Bucks, and Chester Counties and another territory to include the remainder of state. In his conclusion, Mr. Roberts stated that . . . "The data justify moderate changes in territorial differentials. It is likely that later experience will soon further support the findings developed here."

During the discussion of the report's implications, the Commission was reminded that any change in the current territories would require, not only a filing with and approval by the Insurance Deprtment, but extensive administrative changes before new policies could be written based on the territorial changes. Because the current territories have only been in effect for four months, it would be difficult to draw conclusions as to their appropriateness or how they compare with the proposed seven territories suggested in the Woodward & Fondiller study.

PMS legal counsel also reminded the Commission that the settlement agreement recently entered into with Argonaut stipulates that the new insurance company, PMSLIC, could not increase its rates above those currently charged by Argonaut during the period January, 1978 to June, 1978, the period when the Argonaut company will not solicit malpractice insurance in Pennsylvania. It is possible that if PMSLIC becomes operational, a third party beneficiary physician could sue the new company or the PMS as a result of changes in his premium due to a territorial alteration if the territorial change forced him to pay a higher premium than the one he would have paid to Argonaut.

Based on a careful consideration of the Woodward & Fondiller report; PMS legal counsel's opinion; and the views expressed by members of the Committee regarding the consequences that could result in territorial changes, the Commission made the following recommendation:

The Commission on Professional Liability Insurance recommends that the report on territorial structure by Woodward & Fondiller be accepted as informational by the House of Delegates at this time; and further recommends that an additional report be reviewed prior to the 1978 meeting of the House of Delegates for the purpose of comparison. At that time, recommendations as to change in the current territorial structure could be considered if the findings substantiate or confirm these preliminary indications.
It is further recommended that if, prior to the 1978 House of Delegates meeting, should either Argonaut or PMSLIC request a rate adjustment of the Insurance Department, then either company shall be requested to take into consideration the findings of the Woodward & Fondiller Report.

Respectfully submitted,
Henry H. Fetterman, M.D.
Chairman

Appendix M

Supplemental Report

Council on Professional Relations and Services

At its September 24, 1977 meeting, the Council on Professional Relations and Services considered two important items which have been forwarded to the Board of Trustees and Councilors for further review and, hopefully, on to the House of Delegates for action. The two items concerned the establishment of a medical school section and a resident physician section within the Pennsylvania Medical Society organizational structure. Details on each program are as follows:

Resident Physician Section

The Council has studied the formation of a resident physician section for over a year. On the recommendation of the Council, the Board authorized the President of the State Society to appoint a Resident Steering Committee to formulate an appropriate program. The council and the steering committee have been working over the summer months towards the establishment of a formal resident physician section in conjunction with the October meeting of the PMS House of Delegates. To that end, the council has developed a resolution which is to be presented to the Board of Trustees and Councilors for consideration with a request that it be referred to the House for action. The resolution is as follows:

WHEREAS, resident physicians in Pennsylvania have a genuine vested interest in the business of organized medicine within the state and nation; and

WHEREAS, the need for solidarity within the medical profession is ever-increasing as numerous special interest groups and governmental agencies continue the assault on the physician/patient relationship; and

WHEREAS, The AMA formed a Resident Physician Section in 1972 giving House officers voting positions on all major AMA policy boards and a voting delegate to the House of Delegates; and

WHEREAS, AMA Executive Vice President, James H. Sammons, M.D., has stated publicly that active participation by residents is vital to the future of the federation and the solidarity of the medical profession; therefore be it

RESOLVED, That the Pennsylvania Medical Society form a Resident Physician Section to provide a forum within the State Society for the exchange of information among young physicians in training and their more senior colleagues; and be it further

RESOLVED, That the governing committee of the section be formed to meet and carry out the function of the Society between Annual Meetings and that this committee be properly funded; and be it further

RESOLVED, That the State Society will include House officers in the decision or policymaking process affecting all physicians in the state and shall include, but not be limited to, representation in the House of Delegates; and be it further

RESOLVED, That the Pennsylvania Medical Society find it in the best interest of the Society to include the appropriate number of House officers in its delegation to both the annual and interim resident physician section meetings held in conjunction with the AMA annual and interim meetings.

The council attached a fiscal note to the resolution submitted to the Board which indicated that adoption of the resolution would require funds in the amount of approximately $3,000 for the governing committee and an additional $8,000 to $10,000 to sponsor six House officers to attend both the annual and interim Resident

Physician Section meetings held in conjunction with the AMA annual and interim meetings.

The council looks with considerable favor on the eventual formation of a Resident Physician Section in PMS because it believes it will give an added forum to this important segment of the medical community. This voice, it is hoped, can generate increased interest on the part of residents in formulating policy that will affect their future practice in medicine and spur them on to become members of the Society earlier in their careers.

Medical School Section

In June of this year, the AMA sponsored the first meeting of the Medical School Section. The section was established to address the communication gap between medical school deans, faculty, and administrators and organized medicine. The program was considered highly successful and the AMA has requested that State Societies provide a similar forum for the leaders of medical schools in their respective states. The council has reviewed available material on the subject and believes that if a medical school section is established in Pennsylvania, it would indeed increase communication between the Society and the teaching institutions. Such an effort would further strengthen our recruitment effort within this body of physicians and may help to have medical schools speak more positively of organized medicine when discussing the matter with medical students. To that end, the council referred to the Board of Trustees and Councilors a series of recommendations which would establish such a section. The council urged the Board to act favorably on the recommendations and to refer them to the House of Delegates for action. The following is a list of recommendations for the information of the House of Delegates:

1) The section be named "The Section on Medical Schools";

2) Membership in the Section on Medical Schools should include deans of Pennsylvania medical schools if the dean is an active member. If the dean is not eligible for active membership, the dean may designate a representative who is an active member of the Pennsylvania Medical Society;

3) Membership should also include up to five members of administration or faculty of each Pennsylvania medical school, designated by the dean of the school, who are active members of the Pennsylvania Medical Society;

4) The section will elect a chairman, vice chairman, secretary, a delegate and alternate delegate to the Pennsylvania Medical Society House of Delegates. The organization and structure of the section would include, but not be limited to, a business meeting which would be held in conjunction with the PMS House of Delegates session and there should be developed a governing council of the section to consist of the officer and two members elected by the section membership at the business meeting of the section;

5) The cost incurred by the participating members of the section should not be a responsibility of the Pennsylvania Medical Society.

The council sees the establishment of a medical school section as another step toward increasing communication with an important segment of the medical community. We hope that favorable action occurs on this recommendation.

Pennsylvania Medical Society Credit Union

The council received approval to a recommendation to the Board of Trustees and Councilors of the formation of a Pennsylvania Medical Society Credit Union for members, their families, medical society staff, and employees of physicians. The council, in studying this matter, found that credit unions would have a great appeal to the younger physicians, employees of all physicians, and the families and staff of physicians throughout the state. It is believed that the young physicians will find this as a ready source of additional revenue during the years they are establishing a practice. Employees will find this an excellent fringe benefit that their physician employer can provide. The organizational phase of the credit union is planned for the early weeks of November and promotion on the savings and loan aspect of credit union to the membership will occur shortly thereafter. We urge all members of the House of Delegates to look carefully at this unique program and ask that you make it available to your employees as an employee benefit of working with you.

Respectfully submitted,
Robert Poole, III, M.D.
Chairman

Appendix N

Supplemental Report
Committee on Constitution and Bylaws

This report is in response to the referral by the Reference Committee on Reports of Officers at the 1976 Annual Session to the Committee on Constitution and Bylaws to study the recommendation by the Trustee and Councilor of the Twelfth District as published in the Proceedings, November 1976 PENNSYLVANIA MEDICINE, page 81.

The Committee on Constitution and Bylaws reviewed the present system of organization of PMS as outlined in the Constitution, Article VI, Sections 1 and 2, and Article VIII, Section 2, the Articles dealing with composition of the House of Delegates and the Board respectively and determined that system of representation to be functioning adequately.

Respectfully submitted,
Frederick G. Brown, M.D.
Charles A. Heisterkamp, III, M.D.
Edward N. Moser, M.D.
John P. Whiteley, M.D.
Betty L. Cottle, M.D., Chairman
G. Winfield Yarnall, M.D., Secretary
D. Ernest Witt, M.D., Speaker
Donald E. Harrop, M.D., Vice Speaker
Fred Speaker, Esquire
John F. Rineman, Executive Vice President

Appendix O

Supplemental Report
Reports of Individual Councilors
Tenth District
Lawrence County

The Lawrence County Medical Society again conducted monthly Continuing Medical Education Seminars for Physicians in joint sponsorship with the University of Pittsburgh School of Medicine.

The entire program was in conjunction with that which was taking place at St. Francis Hospital and Jameson Hospital. It was held for a total of thirty-two hours in Category I.

Members of the Society again participated in the PA Health Preceptorship Program during the summer months.

Recruitment of new physicians has started to bear fruit. A surgeon, psychiatrist, pediatrician, radiologist and four internists plus one general practitioner have relocated in the New Castle area.

The Recruitment Committee is still actively seeking more physicians. The Society will have six new members added to its roster.

The Future Physicians Club, under the sponsorship of the Women's Auxiliary, is a great success with many more members each year.

Respectfully submitted,
David W. Clare, M.D.
Trustee and Councilor

Appendix P

Report
Judicial Council

At its meeting of October 5, 1977, the Judicial Council considered in depth the ethical aspects of restrictive covenants as they have been used in contractual agreements between physicians. A substantial volume of background material was reviewed relating to recent and current illustrative cases, submissions by letter and in person from interested physicians and legal analysis from counsel for the Pennsylvania Medical Society and the AMA.

The legality of restrictive covenants was not at issue. The central matter for discussion and decision was the need for the Pennsylvania Medical Society to propose modifying the present position of the Judicial Council of the American Medical Association, which reads as follows:

"There is no ethical proscription against suggesting or entering into a reasonable agreement not to practice within a certain area for a certain time, if it is knowingly made, understood, and consistent with local law. Whether it is advisable as being in the best interest of the public depends on all of the surrounding facts.

"Ethically such agreements are not forbidden."

It is the considered opinion of the Judicial Council:

1) That restrictions upon geographical area, and duration of the restrictions, must be reasonable in the interest of the individual circumstances of the contract;

2) That there may indeed be circumstances in which such covenants may be adverse to the public interest, but there are also circumstances in which public interest may well be served or undisturbed, and that such determinations must be made with close attention to the circumstances of the individual case;

3) That all parties entering into contracts containing restrictive covenants should be fully informed of their presence and their effect, preferably with advice of legal counsel; and

4) Once there is informed agreement to the terms of a restrictive covenant, it should be binding unless specific release may be subsequently negotiated.

The Judicial Council has been made aware of the position taken by the American Bar Association in respect to restrictive covenants. It has carefully examined the feasibility of recommending a comparable ethical prescription on the part of the American Medical Association. The conclusion has been reached that this is not appropriate.

The Judicial Council wishes to reaffirm the position adopted by the American Medical Association and to emphasize the importance of a full understanding of all contract provisions before signature.

Respectfully submitted,
Lewis T. Buckman, M.D.
George E. Farrar, Jr., M.D.
Charles K. Rose, M.D.
William A. Limberger, M.D., Vice Chairman
Russell B. Roth, M.D., Chairman

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Case report

Alexia without agraphia due to aneurysm

LAWRENCE P. LEVITT, M.D.
JOSEPH GASTINGER, M.D.
WILLIAM McCLINTIC, D.O.
FRANK LIN, M.D.
Allentown

Alexia without agraphia is a neurological disconnection syndrome in which the patient loses his ability to read but retains his ability to write. It is characteristically due to infarction in the territory of the left posterior cerebral artery due to thrombosis of that vessel. Below we report a case of alexia without agraphia due to rupture of an aneurysm of the posterior cerebral artery.

Case report

W.K., a 65 year old retired custodian, was admitted to the Allentown Hospital on July 21, 1975 for abdominal pain. A medical history revealed that he had suffered a loss of memory for approximately five months and had been unable to read for three months. He reported mild headaches but no paralysis or numbness; there had been no loss of consciousness or convulsion. The abdominal pain was relieved with antacids.

A physical examination revealed normal vital signs and general physical condition, except for tenderness to palpation in the epigastrium.

Neurological examination confirmed a memory impairment. The patient knew the last name of the United States president but not the first name or that of the vice president. He thought the year was 1952. He forgot four of four unrelated objects after five minutes.

He was not aphasic. His speech was fluent; he could name a book, watch, and pen, could repeat phrases, and could put his right thumb on his left ear. He could perform simple calculations. He was unable to read or to identify individual letters, yet he could write. He wrote his name and "The President lives in Washington" without error. He could not identify colors, calling green "brown", and yellow "bluish-red."

Cranial nerves were normal except for a right homonymous hemianopsia.



Figure 1. Left carotid arteriogram reveals a peripheral aneurysm of the parieto-occipital branch of the left posterior cerebral artery.

Motor strength was normal. Deep tendon reflexes were symmetrical. The left plantar response was flexor, the right was equivocal. Sensation was normal.

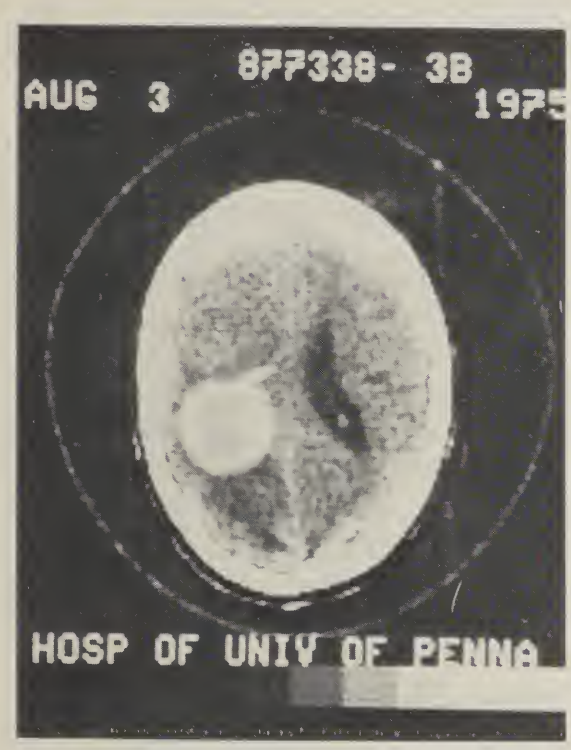
A gastrointestinal series showed a hiatal hernia which apparently explained the epigastric pain. Multiple blood cultures were negative.

The skull x-ray was normal. An electroencephalogram showed left hemisphere slowing posteriorly. A brain scan showed an area of increased uptake in the left parieto-occipital region. A left selective carotid arteriogram (Figure 1) showed a peripheral aneurysm of the parieto-occipital branch of the left posterior cerebral artery. The presence of a surrounding avascular area suggested a hematoma.

A computerized axial tomogram (Figure 2A) confirmed the presence of a hematoma associated with the aneurysm. There was an area of decreased density in the occipital region posterior to the hematoma consistent with an infarct.

In view of the patient's age and his improvement during hospitalization it was decided to follow a conservative nonoperative approach. Follow up over the ensuing six months revealed improvement in reading ability and memory, although neither returned to normal. A repeat computerized axial tomogram six months after the initial study (Figure 2B) revealed no significant change in the size of the hematoma. The center was less dense, however, and there was now a dense

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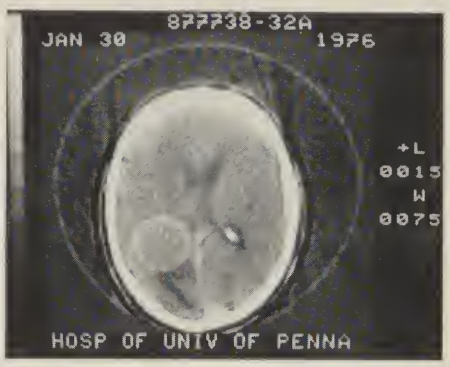


Figure 2B. Computerized axial tomogram six months later reveals no change in size of the hematoma but the center is less dense, and a dense rim suggests calcification. The irregular area of decreased density in the occipital region, posterior to the hematoma, persists.

Figure 2A. Computerized axial tomogram two weeks after admission revealed a spherical density in the left parieto-occipital region whose absorption coefficient was consistent with a hematoma. There was also an irregular area of decreased density posteriorly consistent with an infarct. There was no displacement of midline structures.

rim suggesting calcification. The irregular area of decreased density in the left occipital area remained compatible with an old infarct.

Discussion

Alexia without agraphia was originally described by Dejerine[1] and has been brought to recent attention and amplified by Geschwind.[2,3] In Dejerine's original case, and in others since reported,[4] there was an infarct of the left occipital lobe and of the splenium of the corpus callosum. The syndrome results from a disconnection of the visual cortex and the speech area. The left occipital lobe lesion produces the right homonymous hemianopsia.

Lesion of the splenium prevents words in the left visual field which are perceived in the right occipital lobe from connecting with the language center of the left hemisphere, thus producing the alexia. Because the language center is intact, writing ability is preserved.

The syndrome characteristically occurs from a thrombosis of the left posterior cerebral artery, the vessel which normally supplies the left occipital cortex. Cogan[5] has stated that "alexia without agraphia occurs only with vascular accidents since trauma, tumors and other lesions could scarcely be expected to involve the left occipital lobe and splenium so completely and exclusively. If these other lesions were sufficient to destroy the occiput and splenium, they would almost certainly involve also the angular gyrus in the neighboring parietal lobe, producing the more familiar syndrome of alexia with agraphia."

We know of no other previously reported case in which the vascular accident producing the syndrome of alexia without agraphia was rupture of a posterior cerebral aneurysm. In one series[6] of aneurysms of the posterior cerebral artery a patient who had impairment of memory and a right visual field defect is described. No description of reading or writing abnormality is given.

Review of several other series[7,8] of vertebro-basilar system aneurysms reveals that the distal location of our patient's aneurysm is unusual. This probably explains why other cases of rupture of posterior cerebral aneurysms produce more than alexia without agraphia, in keeping with Cogan's observation.

The severe memory disturbance noted in our case has been reported by others[3,9] and is presumably due to associated infarction of the left hippocampal region.

We thus add rupture of a posterior cerebral aneurysm to the known causes of alexia without agraphia. □

The authors acknowledge the assistance of the Department of Radiology of the Hospital of the University of Pennsylvania in performing the computerized axial tomography, and thank Dr. Herbert Hyman of Allentown for referring the patient.

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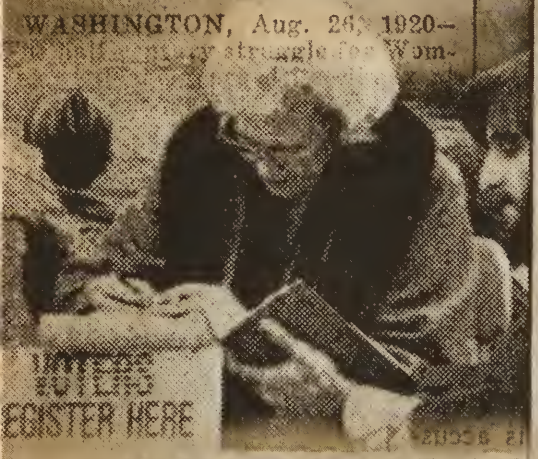
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Social Security Bill Is Signed; Gives Pensions to Aged, Jobl

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WASHINGTON, Aug. 14, 1
The Social Security Bill, prov
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Amendment to Constitution is Sent to House, Where Passage is Expected

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Ends No

WASHINGTON, Jan. 27, 1973—"With the signing of the peace agreement in Paris today, and after receiving a report from the Secretary of the Army that



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Meeting Gives Standing Ovation as Executive Pictures Peace Gain

"If we fail to use it," he declared to the solemn final meeting of the delegates, 'we shall betray all of those who have died in order that we might meet here in freedom and safety to create it.'

"If we seek to use it selfishly—for the advantage of any one nation or any small group of nations—we shall be equally guilty of that betrayal."

Fervent Interpolation

The President, speaking in the auditorium of the War Memorial Opera House, built in memory of sons of the Golden Gate city who gave their lives in the first World War, in which he himself served, seemed to give unconscious expression to the solemn feeling of the occasion when, at the outset of his speech, he interpolated the words, half a hope, half a prayer:

"Oh, what a great day this can be in history!"

Just before the plenary session the President accompanied the

PATIENT PACKAGE INSERTS: A CONCEPT WHOSE TIME HAS COME?

The consumer's right to know is an irreversible and desirable trend of the Seventies. It extends, and properly, to a patient's right to know more about his or her prescription medications. One way, gaining favor, is through patient package inserts. Wisely-prepared and properly distributed when medically indicated, they could markedly improve patient knowledge and drug therapy—laudable goals by anyone's standards.

The PMA endorses these goals and will work with government, the health professions and consumers to achieve them.

The Advantages

The concept holds promise of benefits: better patient understanding of the product prescribed, better adherence to the treatment plan, and more awareness of possible side reactions.

Every doctor has had patients who fail to finish antibiotic regimens because they feel better. Some patients assume that if one tranquilizer or analgesic is good, two may be twice as good. Still others fail to report dizziness while on antihypertensive therapy —and so on.

Problems like these might arise less often if the patient received written information in addition to verbal instructions. Some studies suggest that patients are more receptive to such materials, and they more often understand the verbal instructions and follow them, when inserts are used.

The Disadvantages

There are also some potential problems. Obviously, the inserts must be clearly phrased, without extraneous or complex detail. How much information is enough? How can it be kept current? Should all patients receive the same information? Should inserts be included with all drugs? Should only potential problems be listed or are patients better off with a "fair balance" presentation that describes usefulness as well as drawbacks?

These and similar questions require answers, since model inserts have yet to be properly developed and tested. Despite the need for these studies, the FDA is proceeding prematurely with inserts on selected products. We think the Congress is the only place where the matter can be given the proper legal status and direction, particularly since it represents a conceptual change in the legal, medical and social framework of the nation's prescription drug information system.

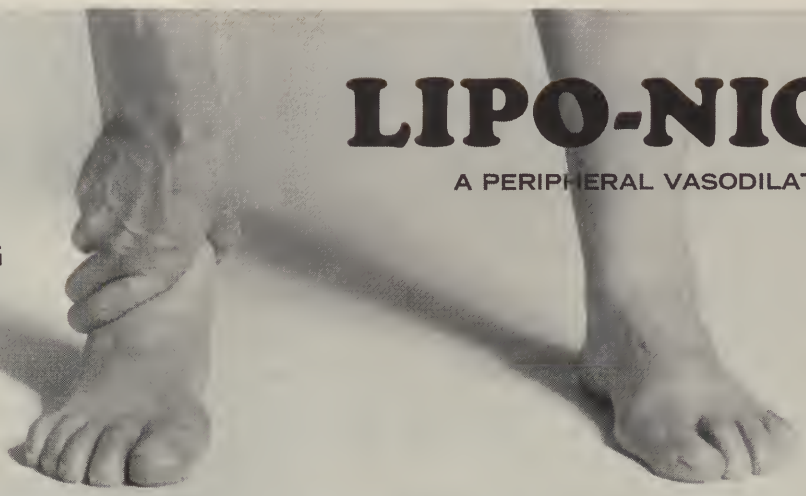
The Solution

The PMA believes that carefully-devised pilot studies of various kinds of inserts are needed. They should be developed and implemented with full participation by doctors, pharmacists, consumers, communications experts and the drug industry. Such studies will provide reliable pathways to follow, so that inserts will be useful aids to medical practice.

And particularly we think that you should be closely involved in this debate and in these studies and decisions. Otherwise, people with less experience and qualifications may control the purposes, content and use of a tool with considerable promise for improved patient care. It could make a difference in your practice tomorrow, and more importantly, in the health of your patients.

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Pyridoxine HCL (B-6).. 10 mg.
DOSE: 1 to 5 tablets daily.
AVAILABLE: Bottles of 100, 500, 1000.

LIPO-NICIN/250 mg.
Each yellow tablet contains:
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Thiamine HCL (B-1) .. 25 mg.
Riboflavin (B-2) ..... 2 mg.
Pyridoxine HCL (B-6).. 10 mg.
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AVAILABLE: Bottles of 100, 500, 1000.

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LIPO-NICIN/300 mg.
Each time-release capsule contains:
Nicotinic Acid .....300 mg.
Ascorbic Acid .....150 mg.
Thiamine HCL (H-1) .. 25 mg.
Riboflavin (B-2) ..... 2 mg.
Pyridoxine HCL (B-6).. 10 mg.
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AVAILABLE: Bottles of 100, 500.

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How to use influenza virus vaccine for 1977-78

The Bureau of Biologics, Food and Drug Administration, reviews influenza vaccine formulation regularly and recommends reformulation with contemporary antigens when indicated. Bivalent influenza vaccine for 1977-78 will contain inactivated influenza A and B viruses representative of currently prevalent strains. Each adult dose of vaccine will contain 400 chick cell agglutinating (CCA) units of antigen or its equivalent in the following proportion: 200 CCA units of influenza A virus comparable to the prototype *A/Victoria/3/75* (H3N2) and 200 CCA units of *B/Hong Kong/5/72 influenza virus.*

The 1977-78 vaccine will be available in "split-virus" and "whole-virus" preparations. Split-virus vaccines, which contain antigens produced by chemically disrupting the influenza virus, have been associated with somewhat fewer side effects than whole-virus, particularly in children. However, the split-virus vaccines appear to be somewhat less effective in eliciting antibodies when given as a single dose to persons who have not been "primed" by exposure to related viruses in nature or through vaccination.

The characteristic side effects and immunogenicity of split-virus and whole-virus influenza vaccines are important in understanding dosage recommendations for various age groups. Adults and older children, most of whom have had experience with influenza antigens related to *A/Victoria/3/75* or *B/Hong Kong/5/72* either by infection or through vaccination, can be expected to have a good antibody response to a single dose of the 1977-78 bivalent influenza vaccine.

Children less than six years old, some of whom have not encountered the currently prevalent viruses, will need two doses of vaccine given four or more weeks apart in order to achieve satisfactory antibody responses. These children will not be adequately protected unless the second dose is given. Furthermore, because children and adolescents tend to experience somewhat more side effects from influenza vaccine than adults, only split-virus vaccines should be given to persons under 18 years of age.

Vaccine usage

Annual vaccination is strongly recommended for adults and children of all ages who have such chronic conditions as: 1) heart disease of any etiology, particularly with mitral stenosis or cardiac insufficiency; 2) chronic bronchopulmonary diseases, such as chronic bronchitis, bronchiectasis, tuberculosis, emphysema, and cystic fibrosis; 3) chronic renal disease; and 4) diabetes mellitus and other chronic metabolic disorders.

The information in this article is based on recommendations of the Public Health Service Advisory Committee on Immunization Practices.

Vaccination is also recommended for older persons, particularly those over age 65, because excess mortality in influenza outbreaks occurs in this age group.

Vaccination also may be considered for persons who provide essential community services and may be at increased risk of exposure. Vaccination of such persons and of patients not specified in the high-risk groups should be made on an individual basis giving consideration to the inherent benefits, risks, and costs.

Table I accompanying this article summarizes vaccine and dosage recommendations by age group for 1977-78. These recommendations are derived from observations made during the field trials of influenza vaccines conducted in 1976. Because information on the immunization of infants and young children is limited, the dosages recommended for them are conservative.

TABLE I Influenza Vaccine Dosage by Age, 1977-78

Age	Product type	Dose volume (ml)	Total CCA units[1]	Number of doses
18 years and older	Whole-virus or Split-virus	0.5	400	1
6-17 years	Split-virus	0.5	400	1
3-5 years	Split-virus	0.25	200	2[2]
6-35 months	Split-virus	0.15	120	2[2]

[1] Representing equal amounts of A/Victoria/75 and B/Hong Kong/72

[2] Four weeks or more between doses; both doses essential for good protection

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Know your taxes

The physician's income tax checklist

DONALD L. DeMUTH, M.B.A., C.P.A.
EDWARD H. ACHORN, M.Adm., C.P.A.
Harrisburg

When the anathematic letters "IRS" are mentioned, many physicians immediately think of a monolithic bureaucracy whose sole function is to take as many of their hard-earned dollars as possible. As each new round of tax laws passes Congress, it appears that legislators are bent on penalizing the hard working and industrious. The only sensible approach for the physician is to pay the smallest amount of federal income tax legally possible.

The purpose of this article is to acquaint doctors with how taxable income and income tax are determined. A checklist of items and commentary are included to assist the physician in compiling information for his tax advisor or in preparing his own return. The checklist is not intended to be all inclusive.

Overview

Before examining individual deductions and items of income, review the computation of taxable income and income tax.

Business deductions, such as aide salaries, office rent, drugs, and supplies, are subtracted from practice income collected to determine the net practice income of a solo practitioner. If the doctor is a partner or employe of a partnership or an employe of a professional corporation, the partnership will determine his share of the practice income or, as an employe, he will receive a W-2 form for his salary. Other income, dividends and interest, for example, are added to the net practice income or salary.

From this total income figure, adjustments to income, moving expenses and alimony, for instance, are deducted. This total is known as the adjusted gross income.

At this point the physician has the option of itemizing deductions or not doing so. If he does not itemize his deductions, such as loan interest and charitable contributions, he is entitled to a deduction of $3,200 if he is married, or $2,200 if he is single. When deciding "to itemize or not to itemize," the physician should determine which method allows him to have the highest deductions.

Also at this time, exemptions of $750 per dependent and additional deductions, if he or his spouse are over 65 or blind, are subtracted. This final figure is the taxable income.

Federal income tax is computed on the taxable income. From this amount tax credits, such as investment credit and child care credit, are subtracted to determine the income tax that must be paid.

The authors are on the faculty of the Pennsylvania State University's Capitol Campus, Middletown. Mr. DeMuth is an assistant professor of accounting and finance and Mr. Achorn is an assistant professor of accounting and management.

TABLE I
Taxable Income and Income Tax Payable (Sample)

Taxable income	
Practice income collected	$85,000
Business deductions	− 34,000
Net practice income	51,000
Other income	+ 5,000
Total income	56,000
Adjustments to income	− 9,000
Adjusted gross income	47,000
Itemized deductions	− 6,000
Exemptions	− 3,000
Taxable income	$38,000
Income tax payable	
Income tax	$11,060
Tax credits	− 560
Income tax payable	$10,500

Table I illustrates the computation of taxable income and federal income tax payable for an unincorporated, solo, primary care physician.

Residents and interns may take advantage of those situations in which $300 per month of their stipend, up to a maximum of 36 months, may not be taxable. The courts have not yet fully decided whether the stipend received by interns and residents is a fellowship to support graduate education or compensation for services; litigation in this area has resulted in decisions both for and against physicians. The most frequently cited case with findings in favor of physicians is *Leathers v. U.S.*, 471 F.2d 856 (8th Cir. 1972). The significant facts are:

1. The residency training was received at a hospital that is only a teaching hospital;
2. Residents worked under close faculty supervision;
3. Residents were not required to remain in the state at the completion of their training;
4. The hospital did not bill patients for residents' services;
5. The work could be performed without the residents.

Based on these points, it appears that MDs in specialties which require constant supervision during the residency program and at hospitals that are only teaching hospitals are eligible for the $300 per month exclusion. (*Note:* At the present time the IRS is attempting to disallow the exclu-

TABLE II
Income Tax Checklist

Income

___ 1. W-2s for salaries
___ 2. 1065s for partnership income
___ 3. 1120-Ss for Subchapter S Corporations
___ 4. Practice accounting and financial records
___ 5. 1099s for dividends and interest
___ 6. Estate and trust income
___ 7. Pension and annuity (possibly part or all not taxed)
___ 8. Stockbroker's advice on purchase and sale of securities
___ 9. Real estate transactions—settlement sheets at purchase and sale (*Note:* update records annually for remodeling, shrubbery, and tree costs.)
___ 10. Rental property income and expenses
___ 11. Awards and prizes (except for achievements and scientific contributions)
___ 12. Books received by reviewer
___ 13. Cancellation of debts (generally)
___ 14. Executor's fees
___ 15. Gambling winnings in excess of losses
___ 16. Jury fees
___ 17. *Exemplary* damages for libel or slander of personal reputation
___ 18. Value of property received
___ 19. State or local tax refund, if previously deducted as itemized deduction

Nontaxable income

___ 1. Accident and health insurance proceeds (if not previously deducted)
___ 2. Damages for personal injury or sickness
___ 3. *Compensatory* damages for slander or libel of personal reputation
___ 4. Employe death benefits (up to $5,000)
___ 5. Disability payments
___ 6. *Life insurance* policy dividends
___ 7. Life insurance proceeds (if not transferred for valuable consideration)
___ 8. Scholarships and fellowships (some limitations)
a. $300 per month exclusion (Sec. 117, *Leathers*)
___ 9. Gifts
___ 10. Inheritances
___ 11. Noncompetitive awards for achievements
___ 12. Social Security benefits

TABLE III
Checklist of Business Deductions

Business (nonitemized) deductions

____ 1. Accounting fees
____ 2. Attorney fees (relating to practice)
____ 3. Appraisal cost (except for property acquired)
____ 4. Conventions and meetings
____ 5. Professional periodicals and journals
____ 6. Uniform purchase and cleaning
____ 7. Education (except for foreign physician attempting to qualify for practice in the U.S.)
____ 8. Pension and profit sharing plan contributions
____ 9. Business gifts up to $25 per recipient
____ 10. Travel deductions
  a. Transportation to temporary assignment
  b. Several locations—commuting from one location to another (but not home-to-office-to-home)
  c. Out of town, overnight (convention, meeting, etc.)
____ 11. Entertainment (e.g., seeking referrals)
  Be prepared to show:
  a. Specific purpose of entertainment
  b. Nature of practice
  c. Length of time in practice and number of existing patients
  d. Percentage of patients received as referrals
  e. Names of people entertained and reason why additional income could be expected from each
  f. Whether referrals were actually received from physicians entertained and indication of the effect of entertainment on referrals
  g. Number of times *individual* physicians were entertained in the year (repeated entertainment indicates personal motive)
  h. Whether or not other doctors in the same type of practice in the same locality have entertainment expenses

No business deduction

____ 1. Gifts arising from professional courtesy

sion for doctors in apparently all instances. The doctor should be prepared to support his contention if audited.)

Table II provides a checklist for taxable and nontaxable income.

Income

In addition to the normal practice and investment income, the physician must pay a capital gains tax if he sells his home for a profit. (The tax on this gain may be deferred subject to special rules if the doctor purchases another residence.) To compute the gain, the physician subtracts from the selling price not only the purchase price of the home, but also costs of additions, remodeling, and landscaping. It is important that the physician keeps records supporting the costs of these major expenditures to assure that he will be able to reduce the taxable gain.

Business deductions

In addition to the costs of running a medical office and the cost of attending professional conferences, the physician can also deduct the cost of entertainment for business purposes. To secure a deduction for entertainment, he must be able to show the names of the people entertained and the purpose for inviting them, with a record of the ultimate business outcome of the entertainment. Entertainment for the purpose of securing referrals is a legitimate business deduction. However, the physician must have meticulous records substantiating the reasons for and cost of entertaining.

Table III provides a checklist of business deductions.

Adjustments to income

As many physicians are aware, moving expenses are deductible from income. These expenses include travel, lodging, and meals while in search of a new residence *after* selecting a new location for the medical practice. It does *not* include travel and associated expenses while in search of a new locale. Other moving expenses include the costs of selling a home or breaking a lease and those of buying a home or acquiring a lease.

Contributions to the retirement plans of unincorporated practitioners are adjustments to income while payments to pension and profit sharing plans are business deductions. The effects of each are identical.

Table IV lists adjustments to income.

Itemized deductions

Medical expenses which are deductible if the physician chooses to itemize his deductions include items which may

TABLE IV
Adjustments to Income

____ 1. Moving expense
  a. Distance from *former* residence to *new* practice location *less* distance from *former* residence to *former* practice location must be 35 miles or more

  Includes:

  b. Pre-move travel, meals, and lodging *after* selecting a new principal work location *and* in search of a residence
  c. Temporary living expenses in a new location (*any* 30 *consecutive* days after selecting principal work location)

  Note: The maximum adjustment for the total of items b and c is limited to $1,500

  d. Expenses of selling former home or breaking lease
  e. Expenses of buying new home or acquiring lease

  Note: The maximum adjustment for the total of items b, c, d, and e is limited to $2,500 subject to the above limitation

  f. Transportation expenses for household goods and personal effects
  g. Travel, meals, and lodging during move

____ 2. Contributions to a self-employed retirement (Keogh) plan ($750 - $7,500; 15%)
____ 3. Contributions to an individual retirement account (IRA) ($1,500 limit, $1,750 with nonworking spouse; 15%)
____ 4. Forfeited interest penalty for premature withdrawal of certificates of deposit
____ 5. Alimony

not be thought of solely as medical expenses. They include such items as food and beverages for specified ailments, corrective devices like orthopedic shoes, prescribed travel, special schooling for handicaps, and air conditioning to alleviate illness. If the physician has parents or grandparents in a nursing home, the entire cost of the nursing home's services is a medical expense provided the parents or grandparents are in the home because of their physical condition and for the available medical care. If they are guests for personal reasons, only the portion of the cost for medical and nursing care is a tax deductible medical expense.

Taxes for which the physician receives no deduction include the federal income tax, Social Security tax on his income or on the portion he pays for domestic workers, gift or estate taxes, and assessments for sidewalks and sewers.

If a doctor pays points (essentially, interest charges at the time of a loan) for the purpose of securing a home mortgage (not for bank services), he may deduct the points in the year paid. If he pays points to secure any other type of loan, the points must be deducted ratably over the length of the loan. For example, a physician paying $200 in points for a five-year personal loan may deduct one-fifth of $200, or $40, per year.

Charitable contributions include not only cash donations, but also property contributions and the costs involved in performing charitable services. There is no deduction, however, for time involved in rendering charitable acts or for blood donations.

Casualty or theft losses in excess of $100 per occurrence are deductible when itemizing deductions. Casualty damages include electrical blackout costs, drought losses, and damages from water pipes freezing and bursting. Termite damage is questionable, since there is doubt whether it meets the tax law's requirement of occurring suddenly. There is never a deduction for items lost, household items damaged while moving or in storage, the value of trees lost through disease, erosion, or moth damaged clothing. Remember, the amount of the loss is limited to the taxpayer's basis in the property (usually his purchase price) or the market value of the property at the time of the loss, whichever is *lower*.

Miscellaneous itemized deductions include the cost of financial planning and consultation, but do not include attorney's fees in preparing a will, obtaining a divorce, or for personal (not tax or investment) affairs. If the physician personally pays expenses, such as professional dues, journals, conventions, and education (as opposed to the practice picking up the tab on these items), he receives an itemized deduction instead of a business deduction for these items.

The doctor has the option of receiving an itemized deduction of up to $100 for political contributions or reducing his

TABLE V
Itemized Deductions

Medical and dental (paid for yourself or your dependents)

____ 1. Medicine and drugs in excess of 1% of adjusted gross income (includes birth control pills)
____ 2. Balance of medical insurance premiums (see comments below)
____ 3. Doctors and dentists
____ 4. Hospitals
____ 5. Hearing aids
____ 6. Dentures
____ 7. Eyeglasses
____ 8. Transportation (7¢ per mile plus parking plus tolls)
____ 9. Food and beverages for specific ailments
____ 10. Rental or purchase of medical equipment
____ 11. Support and corrective devices (e.g., orthopedic shoes)
____ 12. Prescribed travel
____ 13. Special schooling for physical or mental handicaps
____ 14. Psychiatric treatment
____ 15. Treatment at therapeutic center for alcoholism and drug addiction
____ 16. Nursing home (when physical condition and availability of medical care are principal reasons for presence)
a. Medical and nursing care only, when in nursing home for personal reasons
____ 17. Care of mentally or physically disabled dependent
____ 18. Air conditioning to alleviate illness

Note: Deduction for above items is limited to the portion in excess of 3% of adjusted gross income

____ 19. One-half of medical insurance (maximum $150)

Taxes

____ 1. State income tax
____ 2. Local income tax
____ 3. Real estate (not assessments for sidewalks, sewers, etc.)
____ 4. State and local gasoline
____ 5. Sales tax
____ 6. Personal property
____ 7. Occupational

Taxes (no deductions)

____ 1. Federal income tax
____ 2. Social Security tax for self and domestics
____ 3. Estate and inheritance taxes
____ 4. Gift tax
____ 5. Auto licenses (in Pennsylvania)—business portion is a business deduction

Interest (must be for taxpayer's debt)

____ 1. Interest on loans
____ 2. Interest on credit cards
____ 3. Interest on unpaid taxes
____ 4. Interest on margin accounts with brokerage firms
____ 5. Points paid on home mortgage (for the purpose of securing a loan, not for services)
____ 6. Points paid on other loans, ratably over the loan life
____ 7. Penalty on mortgage prepayment

Charitable contributions

____ 1. Cash contributions to U. S. charities
____ 2. Costs of rendering charitable services (transportation @ 7¢ per mile, travel, phone, equipment, meals, and lodging)
____ 3. Ticket to charitable event in excess of fair market value
____ 4. Care of student in home through written agreement with a charitable organization—maximum $50 per month
____ 5. Property (deduction depends on type of property)

Contributions (nondeductible)

____ 1. Services rendered
____ 2. Blood donation
____ 3. Church *member* attending church convention (official delegates only)
____ 4. Contributions to charities for purposes of influencing legislation
____ 5. Raffle tickets
____ 6. Appraisal fees to determine value of donated property

Casualty or theft (sudden, unexpected, or unusual)

____ 1. Fire
____ 2. Storm (damage to trees)
____ 3. Flood
____ 4. Theft
____ 5. Hurricanes
____ 6. Blasts
____ 7. Vandalism
____ 8. Electrical blackout
____ 9. Collision
____ 10. Termite damage (questionable)
____ 11. Drought
____ 12. Earthquake
____ 13. Water pipes freezing and bursting
____ 14. Riots

Casualty or theft (nondeductible)

____ 1. Tree diseases
____ 2. Moth-damaged clothes
____ 3. Erosion
____ 4. Excavation on adjacent property
____ 5. Household goods damaged in storage or transit
____ 6. Lost items (especially jewelry)

Miscellaneous

____ 1. Tax return preparation
____ 2. Financial planning and consultation
____ 3. Dues to professional societies
____ 4. Education expenses (maintains or improves existing skills or is required to retain existing position)
____ 5. Professional journals
____ 6. Professional meetings and conventions (if spouse accompanies, deduct difference between double and single occupancy)
____ 7. Professional licenses
____ 8. Clothing used only for working (cost and cleaning)
____ 9. Investor's expenses
a. Safe deposit boxes
b. Investment counsel fees
c. Legal fees
d. Travel expenses
e. Custodian fees
f. Dividends paid on stock borrowed to cover short sales
____ 10. Business entertainment
____ 11. Political contributions (maximum $100 per taxpayer or credit)

Miscellaneous (nondeductible)

____ 1. Attorney fees (preparing will, obtaining divorce, personal affairs)
____ 2. Tax *penalty* payments
____ 3. Commuting between home and work
____ 4. Traveling in search of employment
____ 5. Adoption expenses
____ 6. Spouse accompanying on trip to convention or meeting
____ 7. Meals while on call and required to be in hospital
____ 8. Multiple trips between residence and principal working location during a single day

income tax to be paid by a maximum of the lesser of $25 or one-half his political contributions (a tax credit).

There is no deduction for tax *penalty* payments; however, there is an interest deduction for the *interest* paid on delinquent taxes. No deduction is allowed for traveling from home to office, no matter how many trips are made each day.

Table V lists itemized deductions.

Capitalized items

Other items on which a physician spends money cannot be immediately deducted in determining taxable income but can be amortized, just as a building is depreciated. For instance, attorney fees and title costs paid in acquiring an office building cannot be deducted in the year paid, but are added to the cost of the property and the property is depreciated over its estimated useful life. If a professional license lasts more than a year, it should be amortized over the duration of the license. Professional books, too, should be capitalized and depreciated over the expected useful life. The physician who buys an existing practice and pays a portion of the selling price for the patients' charts may depreciate the acquired charts over their average useful life.

Table VI lists those items that may be capitalized.

TABLE VI
Capitalized Items

____ 1. Attorney fees for acquiring property (add to cost of property)
____ 2. Title costs (add to cost of property)
____ 3. Costs of investigating prospective business (add to cost of business)
____ 4. Fees in obtaining professional license (amortize over duration of license)
____ 5. Professional books (depreciate over useful life)
____ 6. Building, furniture, fixtures, and equipment (depreciate over useful life)
____ 7. Patient charts *acquired* (depreciate over average useful life)

Tax computation

After subtracting the deductions and personal exemptions from adjusted gross income, taxable income is determined. There are three methods of computing income tax which affect most practitioners.

The regular method involves computing the tax using the tax rate schedules or tax tables. For physicians whose incomes have jumped about 20 percent or more above the average for the previous four years, the income averaging method may allow them to pay less tax than if they use the tax rate schedules or tables. This is important to physicians leaving their residency programs and entering private practice.

For single practitioners with taxable income over $38,000 and married practitioners with taxable income over $52,000, the maximum tax on earned income method may very likely cause them to pay the least amount of income tax possible. The maximum tax on earned income method allows the physician to pay at most 50 percent of his income earned from personal services in taxes, while investment income may be taxed up to the 70 percent bracket.

Table VII, in conjunction with the other checklists, may serve as a reminder of the method chosen.

TABLE VII
Computation of Tax

____ 1. Regular (tax rate schedules or tax tables)
____ 2. Income averaging
____ 3. Maximum tax on earned income

Income tax credits

Once the income tax is computed on the taxable income, the physician may be entitled to credits which reduce the amount of tax he has to pay. A credit ranging from 3⅓ percent to 10 percent of the cost of office equipment and furniture (tangible personal property) lasting at least three years is available. When both parents work or one works and the other is a student, a credit of 20 percent of child care costs with a maximum of $400 for one child and $800 for two or more children is allowed.

Table VIII provides a checklist of tax credits.

TABLE VIII
Tax Credits

____ 1. Investment credit for

Life (years)	at	Percentage of cost
3-4		3⅓
5-6		6⅔
7+		10

Includes:
a. Auto (business portion)
b. Office equipment and furniture used in the office
c. Elevators and escalators (except in apartment building)
d. Leased equipment (in writing from lessor)
e. Coin operated vending machines, washers, and dryers used in residential rental property
f. Fire extinguishers
g. Removable partitions
h. Signs
i. Wall-to-wall carpeting in office
j. Not on real estate

____ 2. Political contributions (½ of contributions—maximum $25 per taxpayer or itemized deduction)
____ 3. Child care (both work or one is student—maximum $400 for one child, $800 for two or more children)

If you have further questions about particular tax ramifications, you should contact your management consultant, accountant, or attorney for guidance. The bromide "an ounce of prevention is worth a pound of cure" holds true in tax matters as well as in medicine. Successful planning allows the physician to keep more of the fruits of his labor *and* to keep the IRS at bay. □

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*R. B. Greenblatt, M.D.; R. Witherington, M.D.,; I. B. Sipahioglu, M.D.; Hormones for Improved Sexuality in the Male and Female Climacteric. **Drug Therapy,** Sept. 1976.

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obituaries

• Indicates membership in the Pennsylvania Society at time of death.

• **Bruce R. Austin,** Schaumberg, Illinois; University of Nebraska College of Medicine, 1932; age 70; died October 1, 1977.

• **Alvin E. Bulger,** St. Petersburg, Florida; University of Pittsburgh School of Medicine, 1901; age 92; died October 3, 1977.

• **Luscian W. DiLeo,** Allentown; Creighton University School of Medicine, Nebraska, 1941; age 69; died October 10, 1977. He had practiced dermatology in Allentown from 1946 to 1958 and had served as director of pediatrics and president of the medical executive board of Sacred Heart Hospital. He was a past president of the Lehigh County Unit of the American Cancer Society and the Lehigh County Medical Society.

• **William Gordon,** Philadelphia; University of Pennsylvania School of Medicine, 1925; age 78; died November 5, 1977. He was an ear, nose, and throat specialist in Philadelphia for 51 years and had taught medicine at the University of Pennsylvania School of Medicine for 39 years before retiring as professor emeritus.

• **Benjamin M. Hand,** Philadelphia; Hahnemann Medical College, 1934; age 66; died September 12, 1977. He had practiced neurology in Philadelphia for 43 years and had taught neurology at Hahnemann Medical College.

• **Mark A. Hennessey,** Clarks Summit; Temple University School of Medicine, 1956; age 47; died September 23, 1977. He had been chief pathologist at Moses Taylor Hospital in Scranton.

• **Stephen A. Hilton,** McKeesport; University of Pittsburgh School of Medicine, 1934; age 67; died May 15, 1977.

• **Joseph F. Hines,** Waverly; Georgetown University School of Medicine, 1932; age 71; died October 2, 1977.

• **Lewis H. Hitzrot,** Princeton, New Jersey; Harvard Medical School, 1924; age 80; died August 22, 1977. He was a practicing internist and instructor and associate in medicine at the University of Pennsylvania for ten years before accepting the post of medical director of Mercersburg Academy in 1936, from which he retired in 1964.

• **Charles B. Hollis,** Merion; Hahnemann Medical College, 1912; age 87; died October 11, 1977. He was appointed to the State Board of Medical Education and Licensure in 1959 and was made chairman in 1964. He was professor and chairman of otolaryngology at Hahnemann from 1938 to 1949, and became professor emeritus in that year. In 1973 he was awarded the Great Hahnemann Medal for distinguished service and in 1976 he received a plaque for 60 years of voluntary service. Dr. Hollis served as secretary to Hahnemann's board of trustees until his death.

• **Edith M. Johnson,** West Chester; Medical College of Pennsylvania, 1924; age 86; died August 20, 1977. She was a practicing physician in West Chester for more than 50 years.

• **Joseph Loughrey,** Pittsburgh; University of Pittsburgh School of Medicine, 1924; age 80; died October 31, 1977.

• **Luther M. Marshall,** Meadville; University of Pittsburgh School of Medicine, 1934; age 67; died October 24, 1977. Dr. Marshall had practiced surgery in Meadville for 42 years.

• **George D. McGrew,** Sharon; University of Pittsburgh School of Medicine, 1931; age 70; died September 16, 1977. He had practiced ophthalmology for 40 years and had served in the Air Force Medical Corps, from which he retired as a lieutenant colonel, for 14 years.

• **John S. Niles,** Carbondale; Columbia University College of Physicians and Surgeons; 1933; age 70; died September 26, 1977. He had held teaching appointments in the departments of surgery at Hahnemann Medical College and the University of Pennsylvania School of Medicine, had served as chief surgeon of the Lehigh Valley Railroad, and was a past president of the Pennsylvania Chapter of the American Cancer Society.

• **William A. O'Connell,** Philadelphia; Jefferson Medical College, 1946; age 55; died October 26, 1977. He had practiced surgery in the Chestnut Hill area for 22 years and had served as an Air Force flight surgeon during the Korean War.

• **Charles K. Rose, Jr.,** Allentown; University of Pennsylvania School of Medicine, 1928; age 76; died November 11, 1977. He had been active in organized medicine, serving as president of the Lehigh County Medical Society in 1951, president of the Pennsylvania Academy of General Practice in 1952, and delegate to the Pennsylvania Medical Society House of Delegates for many years. In 1970 he was elected to the State Society Judicial Council, on which he served until his death.

• **Dwight R. Sipes,** Everett; Cincinnati Medical College, 1922; age 84; died October 11, 1977. Dr. Sipes had practiced medicine in Bedford County for 55 years. He was the first intern and surgical resident at Sacred Heart Hospital in Allentown, and was instrumental in the founding and opening of the former Everett Hospital in 1931 and the Bedford County Memorial Hospital in 1951.

• **Harold A. Taggart,** Rosemont; Hahnemann Medical College, 1919; age 82; died November 12, 1977. Dr. Taggart was a former member of Hahnemann's board of trustees, assistant dean of the college from 1950 to 1955 and acting dean from 1955 to 1957. He was named medical director of Hahnemann Hospital in 1956 and associate dean of the college in 1957, both posts he held until his retirement in 1962.

• **Ralph M. Tidd, Jr.,** Erie; Temple University School of Medicine, 1935; age 69; died October 31, 1977.

• **Jerome M. Waldron,** Philadelphia; University of Pennsylvania School of Medicine, 1943; age 59; died September 10, 1977. He had taught physiology at Jefferson Medical College, Temple University School of Medicine, and Hahnemann Medical College and was on the staffs of Nazareth and Holy Redeemer hospitals. He was responsible for devising a simple test for pancreatic enzymes and for extensive research on blood coagulation.

• **Jacob H. Zweig,** Philadelphia; University of Vienna, Austria, 1936; age 68; died October 4, 1977. He had practiced family medicine in Philadelphia for many years and had been a fellow of the American Geriatric Society.

Joel Goldman, Pittsburgh; Jefferson Medical College, 1931; age 70; died October 7, 1977. He had practiced medicine in Johnstown for 22 years and was a former director of the arthritis clinic at Memorial Hospital. He was a past president of the United Cerebral Palsy of Cambria County and served on the board of directors of the Central Pennsylvania Chapter of the Arthritis Foundation for a number of years.

Edward J. Leganza, Canadensis; Temple University School of Medicine, 1946; age 54; died September 20, 1977.

Leroy R. Purcell, Heckscherville; Hahnemann Medical College, 1924; age 77; died September 23, 1977. He had practiced medicine in the Pottsville area for more than 50 years.

Stanley Z. Weisshaus, Sun City, Florida; Columbia University College of Physicians and Surgeons, 1933; age 75; died September 27, 1977. He had practiced in Clearfield from 1957 until his retirement in 1970 and had served as president of the Clearfield County Medical Society and the Clearfield-Jefferson Heart Association and as a board member of the Clearfield County Unit of the American Cancer Society and the Allegheny Mountain Heart Association.

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(chlordiazepoxide HCl)
THE ANXIETY-SPECIFIC



1. AN EXCEPTIONAL RECORD OF ANTIANXIETY PERFORMANCE
Proven effectiveness within a wide margin of safety

2. A DOCUMENTED RECORD OF FAVORABLE EXPERIENCE
More than a decade and a half of effective clinical use

3. A CONSISTENT PATTERN OF PATIENT RESPONSE
Specific, predictable antianxiety action

4. AN OUTSTANDING RECORD OF SAFETY
Seldom associated with serious side effects (the most common are dose-related and, therefore, largely avoidable)

5. USED CONCOMITANTLY WITH MANY PRIMARY MEDICATIONS
Little or no interference with many primary medications

LIBRIUM®
(chlordiazepoxide HCl)
5 mg, 10 mg, 25 mg capsules

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Warn patients that mental and/or physical abilities required for tasks such as driving or operating machinery may be impaired, as may be mental alertness in children, and that concomitant use with alcohol or CNS depressants may have an additive effect. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral–Adults:* Mild and moderate anxiety and tension, 5 or 10 mg *t.i.d.* or *q.i.d.*; severe states, 20 or 25 mg *t.i.d.* or *q.i.d.* *Geriatric patients:* 5 mg *b.i.d.* to *q.i.d.* (See Precautions.)

Supplied: Librium® (chlordiazepoxide HCl) *Capsules,* 5 mg, 10 mg and 25 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available singly and in trays of 10. Libritabs® (chlordiazepoxide) *Tablets,* 5 mg, 10 mg and 25 mg—bottles of 100 and 500. With respect to clinical activity, capsules and tablets are indistinguishable.

ROCHE
Roche Products Inc.
Manati, Puerto Rico 00701

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The current status of Librium (chlordiazepoxide HCl) in the treatment of anxiety and conditions aggravated by anxiety has been achieved as a result of clinical experience so extensive that it demanded a computerized storage and retrieval system.

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Librium offers you a documented record of efficacy supported by clinical experience in millions of patients.



THAT'S WHAT MAKES LIBRIUM® LIBRIUM®

chlordiazepoxide HCl/Roche



THE ANXIETY-SPECIFIC

Please see summary of product information on preceding page.

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Pennsylvania Medicine

Vol. 81, No. 2 FEBRUARY 1978

COMMON PSYCHIATRIC EMERGENCIES: EVALUATION AND MANAGEMENT

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COMMON PSYCHIATRIC EMERGENCIES: EVALUATION AND MANAGEMENT

Pennsylvania Medicine

Vol. 81, No. 2 FEBRUARY 1978

Her next attack of cystitis may require

the Bactrim 3-system

1. In the urinary tract

Highly effective with fewer recurrences compared to ampicillin or cephalexin

Bactrim has shown high effectiveness not only against *Escherichia coli*, the major uropathogen, but also against most other *Enterobacteriaceae* involved in recurrent UTI. Substantially fewer recurrences have been recorded with Bactrim, as compared to ampicillin or cephalexin.*

Results one month after cessation of treatment

	No. of patients	Antimicrobial therapy	% Negative cultures†
Study 1	80	10-day Bactrim	71.3
	76	10-day ampicillin	56.6
Study 2	60	28-day cephalexin	56.7

Bactrim tablets were used. Bioequivalency studies show one Bactrim DS tablet to be equivalent to two regular strength Bactrim tablets.

*Data on file, Medical Department, Hoffmann-La Roche Inc.
†Criterion: 1000 or fewer organisms/ml urine.

2. In the vaginal tract

It appears from recent studies that the likelihood of recurrent UTI is enhanced by the establishment of large numbers of *E. coli* or other uropathogens on the vaginal introitus.

Bactrim combats uropathogens colonizing the vaginal introitus

Trimethoprim has the distinctive ability to diffuse into vaginal fluid in effective concentrations, thereby reducing or eliminating the number of pathogens in the vaginal introitus, from which they often migrate into the urethra. Bactrim acts to minimize this source of recurrent cystitis in the female.



ROCHE

counterattack

3. In the lower intestinal tract

By its selective action against *Enterobacteriaceae* in the bowel, Bactrim reduces the risk of introital colonization by fecal uropathogens.

Attacks colonic reservoir of uropathogens without significant effect on normal ecologic balance

Bactrim's wide spectrum makes it valuable against most gram-negative bacteria that cause UTI recurrences, yet Bactrim has *no* significant effect on other normal, necessary intestinal flora. Also, Bactrim has rarely been found to cause the intestinal discomfort or fungal overgrowth often associated with broad-spectrum antibiotics.



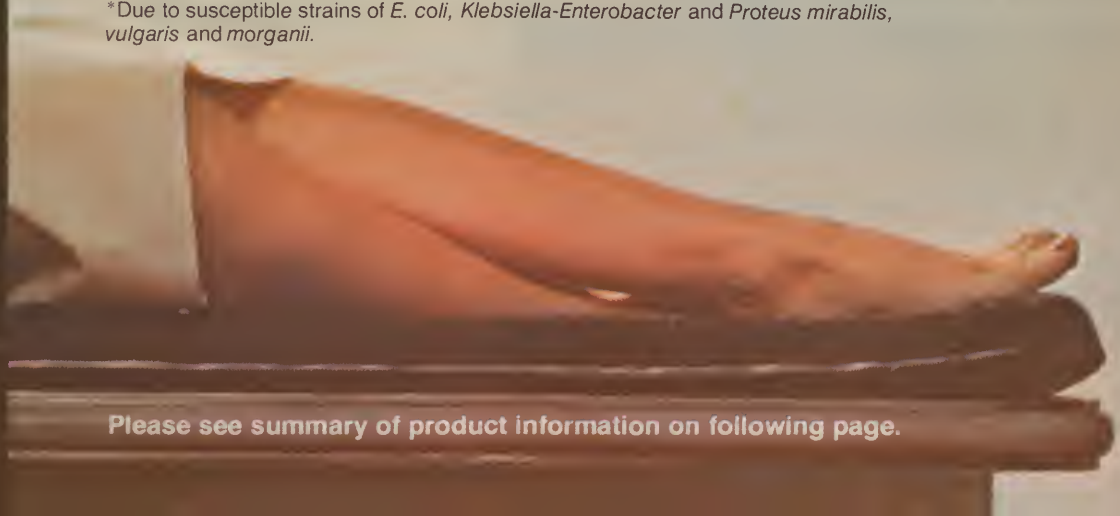
Bactrim™ DS Double Strength Tablets

Each tablet contains 160 mg trimethoprim and 800 mg sulfamethoxazole.

Just one tablet b.i.d.

To clear her infection* and combat reinfecting organisms

*Due to susceptible strains of *E. coli, Klebsiella-Enterobacter* and *Proteus mirabilis, vulgaris* and *morganii.*



Please see summary of product information on following page.

For recurrent attacks of urinary tract infection in women

the Bactrim 3-system counterattack

- Acts on pathogens at vaginal and lower intestinal sites, in addition to urinary tract; helps eliminate reservoirs of reinfecting organisms
- Antimicrobial synergism plus wide-spectrum effectiveness
- Low incidence of bacterial resistance
- Contraindicated during pregnancy and the nursing period; during therapy, maintain adequate fluid intake, perform CBC's and urinalyses with microscopic examination



Bactrim™ DS

Each tablet contains 160 mg trimethoprim and 800 mg sulfamethoxazole.

Double Strength Tablets
Just one tablet b.i.d. for 10 to 14 days

- Day-and-night action against uropathogens
- B.I.D. regimen encourages patient compliance
- Offers high effectiveness with economy

Bactrim™ Tablets

Each tablet contains 80 mg trimethoprim and 400 mg sulfamethoxazole.

Two tablets b.i.d. for 10 to 14 days

Before prescribing, please consult complete product information, a summary of which follows:

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli, Klebsiella-Enterobacter, Proteus mirabilis, Proteus vulgaris, Proteus morganii.* **It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination.** *Note:* The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

Also for the treatment of documented *Pneumocystis carinii* pneumonitis. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.

The recommended quantitative disc susceptibility method (*Federal Register, 37*:20527-20529, 1972) may be used to estimate bacterial susceptibility to Bactrim. A laboratory report of "Susceptible to trimethoprim-sulfamethoxazole" indicates an infection likely to respond to Bactrim therapy. If infection is confined to the urine, "Intermediate susceptibility" also indicates a likely response. "Resistant" indicates that response is unlikely.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers; infants less than two months of age.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age. *Urinary tract infections:* Usual adult dosage—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days.

Recommended dosage for children—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. A guide follows:

Children two months of age or older:

Weight		Dose—every 12 hours	
lbs	kgs	Teaspoonfuls	Tablets
20	9	1 teasp. (5 ml)	½ tablet
40	18	2 teasp. (10 ml)	1 tablet
60	27	3 teasp. (15 ml)	1½ tablets
80	36	4 teasp. (20 ml)	2 tablets or 1 DS tablet

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	½ the usual regimen
Below 15	Use not recommended

Pneumocystis carinii pneumonitis: Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: *Double Strength (DS) tablets*, each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100. *Tablets*, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40, available singly and in trays of 10. *Oral suspension*, containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole, fruit-licorice flavored—bottles of 16 oz (1 pint).

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

medigram

ASSESSMENT TOTAL NEARS $8 MILLION A total of $7,886,000 in assessments has been paid by PMS members and transferred to the Pennsylvania Medical Society Liability Insurance Company (PMSLIC) as of January 29, 1978. Of the 11,523 dues paying members who paid the mandatory assessment, 4,546 also paid the selective assessment, indicating their desire to become PMSLIC insureds. Notices of termination of membership, effective February 15, 1978, were mailed to all active dues paying members who had not paid the mandatory assessment by January 15, 1978.

ARBITRATION SYSTEM FEE STATEMENTS DELAYED Paul F. Abrams, Esquire, administrator of Arbitration Panels for Health Care, has told Society officers that he has delayed mailing fee statements to physicians in order to let the Legislature act on H.B. 1934, which would permit the annual fee to be lowered from $50 to $25. An estimated $500,000 a year in savings is projected.

BOARD OF TRUSTEES ASSAILS ADDED PAPERWORK The Society's Board of Trustees on January 25 refused to endorse new invoice and enrollment and agreement forms of the proposed Medical Assistance Management Information System (MAMIS) of the Pennsylvania Department of Public Welfare. The Society's Council on Medical Service studied the new forms and found them to be "invasive and burdensome to physicians, particularly in view of the inadequate reimbursement level."

PaMPAC DIRECTORS REAPPOINTED The Pennsylvania Medical Political Action Committee (PaMPAC) recently reappointed to its Board of Directors the following physicians: First District, Paul S. Friedman, M.D., Elkins Park; Second, Norman Goldstein, M.D., Phoenixville; Third, Charles K. Zug, III, M.D., Bethlehem; Fourth, David Scicchitano, M.D., Mt. Carmel; Fifth, Paul F. Kase, M.D., Harrisburg; Sixth, Joseph Silverman, M.D., Altoona; Seventh, J. Preston Hoyle, M.D., Lewisburg; Eighth, Anthony Merski, M.D., Erie; Ninth, Robert Goldstrohm, M.D., Indiana; Tenth, Michael P. Levis, M.D., Pittsburgh; Eleventh, William J. Mitchell, M.D., Uniontown; and Twelfth, George E. Hudock, M.D., Courtdale.

MEDICARE PAYMENTS PUBLIC INSPECTION DUE The Bureau of Health Insurance has ordered all medicare carriers (Pennsylvania Blue Shield in the Commonwealth) to prepare by April 1 a list of payments made to physicians and suppliers in 1977. The list will be made available for public inspection in compliance with Public Law 94-409, the government in sunshine act. Blue Shield has mailed payment data statements to all physicians who received medicare payments during 1977 and has asked for a report of any errors on the statements within 30 days of the statement receipt.

SOCIETY TESTIFIES AT LAETRILE HEARINGS David W. Clare, M.D., of Pittsburgh, member of the Society's Board of Trustees, presented the Society's policy statement at a public hearing on laetrile scheduled by the Committee on Health and Welfare of the Pennsylvania House of Representatives. Dr. Clare testified that "...research, in my opinion, has conclusively proven that laetrile in the treatment of cancer is useless...laetrile is a fraud...legalization of laetrile in Pennsylvania would be a disservice of considerable magnitude for cancer victims and their families." Secretary of Health Leonard Bachman, M.D., also testified, calling laetrile "worthless, dangerous, and capable of causing acute cyanide poisoning." S.B. 901, which passed the Senate in July 1977, would legalize the prescribing of laetrile by physicians for use as a dietary supplement.

HEALTH PLANNING GUIDELINES COMMENTS DUE The Society's Commission on Health Planning is receiving comments for review in preparation for the submission by February 21 of a composite critique of the proposed National Guidelines for Health Planning. Initially issued last September, HEW's proposal was revised after an outpouring of criticism of its plan to eliminate one hospital bed in every ten by 1984. The revised proposal provides for local planning agencies to adjust the federal standards to the needs of an individual community. The revised federal standard now says there should be fewer than four hospital beds per 1,000 population and that the beds should be occupied 80 percent of the time.

SOCIETY MEMBERSHIP SHOWS GROWTH Total Society membership on December 31, 1977 was 14,657, an increase of 440 over December 31, 1976. The number of active dues paying members increased by 161; the number of intern/resident members by 105.

BOARD SUPPORTS VOLUNTARY COST CONTAINMENT The Society's Board of Trustees on January 25 approved a cooperative effort to develop voluntary health cost containment plans. It approved the formation of a subcommittee on health care costs of the Council on Medical Service to work with the Hospital Association of Pennsylvania in the effort. The action is a response to the call for a "massive grassroots program of voluntary cost containment" by the American Medical Association, American Hospital Association, and the Federation of American Hospitals. The three national organizations formed a steering committee on cost containment in response to a November 2, 1977 challenge by U.S. Representative Daniel Rostenkowski asking U.S. health providers to voluntarily contain health costs.

COST CONTROL CONFERENCE SET A two day cost control conference, cosponsored by the State Society, the Hospital Association of Pennsylvania, and the Pennsylvania Osteopathic Medical Association, is scheduled for the summer. Invited participants will include leaders from business and industry, organized labor, and insurance, as well as health care providers. The National Health Care Management Center of the University of Pennsylvania will administer the conference, which has as its goal the development of voluntary strategies for cost containment.

BOARD AFFIRMS DISCRIMINATION STAND The Board of Trustees reiterated the opposition voiced by the Society's House of Delegates in October 1977 to discrimination against non-participating physicians by third party payers. The Board action also supports a resolution passed by the AMA House of Delegates in December 1977 which opposes a policy of Blue Cross and Blue Shield of Michigan (BCBSM) to pay a higher reimbursement to subscribers who go to a participating doctor for vision and hearing care. BCBSM established the policy after the auto industry and the United Auto Workers demanded a curb on costs of medical services, which have been growing at an annual rate of 20 percent since 1970.

IMPAIRED PHYSICIAN PROGRAM ADOPTED The Board of Trustees acted January 25 to establish a permanent Impaired Physician Committee charged with implementing a program aimed at locating, contacting, and rehabilitating physicians suffering from alcoholism, drug addiction, or other physical or mental problems. The Board's ad hoc committee on the impaired physician, chaired by Edward J. Resnick, M.D., of Philadelphia, was discharged, having accomplished its original charge to study and recommend a program for the impaired physician.

Pennsylvania Medicine

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Kaon® Elixir
(potassium gluconate)

Kaon® Tabs
(potassium gluconate)

BRIEF SUMMARY
Kaon Tablets/Kaon Elixir

KAON® (potassium gluconate) TABLETS

Description: Each sugar-coated tablet supplies 5 mEq. of elemental potassium (as potassium gluconate 1.17 Gm.). Kaon Tablets are sugar coated, not enteric coated, which favors dissolution in the stomach and absorption before reaching the small intestine where the lesions with enteric potassium chloride have occurred. The sugar coating merely adds to palatability and ease of swallowing, not to delay absorption as does the enteric coating.
Indications: Oral potassium therapy for the prevention and treatment of hypokalemia which may occur secondary to diuretic or corticosteroid administration. It may be used in the treatment of cardiac arrhythmias due to digitalis intoxication.
Contraindications: Severe renal impairment with oliguria or azotemia, untreated Addison's disease, adynamia episodica hereditaria, acute dehydration, heat cramps and hyperkalemia from any cause.
Warning: There have been several reports, published and unpublished, concerning nonspecific small-bowel lesions consisting of stenosis, with or without ulceration, associated with the administration of enteric-coated potassium tablets alone or when they are used with nonenteric-coated thiazides or certain other oral diuretics. These small-bowel lesions have caused obstruction, hemorrhage and perforation. Surgery was frequently required and deaths have occurred. Available information tends to implicate enteric-coated potassium salts, although lesions of this type also occur spontaneously. Therefore, coated potassium-containing formulations should be administered only when indicated and should be discontinued immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur. Coated potassium tablets should be used only when adequate dietary supplementation is not practical.
Precautions: In response to a rise in the concentration of body potassium, renal excretion of the ion is increased. With normal kidney function, it is difficult, therefore, to produce potassium intoxication by oral administration. However, potassium supplements must be administered with caution, since the amount of the deficiency or daily dosage is not accurately known. Frequent checks of the clinical status of the patient, and periodic ECG and/or serum potassium levels should be made. High serum concentra-

1954
1978

Time is the test of all things



tions of potassium ion may cause death through cardiac depression, arrhythmias or arrest. This drug should be used with caution in the presence of cardiac disease.

In hypokalemic states, especially in patients on a salt-free diet, hypochloremic alkalosis is a possibility that may require chloride as well as potassium supplementation. In these circumstances, Kaon (potassium gluconate) should be supplemented with chloride. Ammonium chloride is an excellent source of chloride ion (18.7 mEq. per Gram), but it should not be used in patients with hepatic cirrhosis where ammonium salts are contraindicated. Other sources for chloride are sodium chloride and Diluted Hydrochloric Acid, U.S.P.

It should also be kept in mind that ammonium cycle cation exchange resin, sometimes used to treat hyperkalemia, should not be administered to patients with hepatic cirrhosis.

Adverse Reactions: Nausea, vomiting, diarrhea and abdominal discomfort have been reported. The symptoms and signs of potassium intoxication include paresthesias of the extremities, flaccid paralysis, listlessness, mental confusion, weakness and heaviness of the legs, fall in blood pressure, cardiac arrhythmias and heart block. Hyperkalemia may exhibit the following electrocardiographic abnormalities: disappearance of the P wave, widening and slurring of QRS complex, changes of the S-T segment, tall peaked T waves, etc.

Overdosage: Potassium intoxication may result from overdosage of potassium or from therapeutic dosage in conditions stated under "Contraindications." Hyperkalemia, when detected, must be treated immediately because lethal levels can be reached in a few hours.

KAON® (potassium gluconate) ELIXIR

Description: Each 15 ml. (tablespoonful) supplies 20 mEq. of elemental potassium (as potassium gluconate, 4.68 Gm.) with saccharin and aromatics. Alcohol 5%.

Indications: See Kaon Tablets.

Precautions: See Kaon Tablets.

In hypochloremic alkalosis, potassium replacement with potassium chloride (e.g., Kaochlor® 10% Liquid) may be more advantageous than with other potassium salts.

Adverse Reactions: See Kaon Tablets.

Overdosage: See Kaon Tablets.

WARREN-TEED
LABORATORIES, INC.
DIVISION OF **ADRIA LABORATORIES INC.**
COLUMBUS, OHIO 43215


"...Sleep that knits up the ravell'd sleave of care..."
– WILLIAM SHAKESPEARE, MACBETH, ACT II, SC. 2

Insomnia
a shade of blue that often accompanies depression

And, in anxiety/depression, Adapin® (doxepin HCl) often helps restore disturbed sleep patterns, such as early morning awakening, with a single daily dose at bedtime.[1] Adapin quickly relieves the patient's anxiety, gradually brightens his mood and outlook, with optimal antidepressant response usually evident within two to three weeks.

1. Goldberg HL, Finnerty RJ, Cole JO: Doxepin: Is a single daily dose enough? *Am J Psychiatry* 131:1027-1029, 1974.

Brief Summary of Prescribing Information
ADAPIN® (doxepin HCl) Capsules

Indications—Relief of symptoms of anxiety and depression.

Contraindications—Glaucoma, tendency toward urinary retention, or hypersensitivity to doxepin.

Warnings—Adapin has not been evaluated for safety in pregnancy. No evidence of harm to the animal fetus has been shown in reproductive studies. There are no data concerning secretion in human milk, or on effect in nursing infants.

Usage in children under 12 years of age is not recommended. MAO inhibitors should be discontinued at least two weeks prior to the cautious initiation of therapy with this drug, as serious side-effects and death have been reported with the concomitant use of certain drugs and MAO inhibitors.

In patients who may use alcohol excessively potentiation may increase the danger inherent in any suicide attempt or overdosage.

Precautions—Drowsiness may occur and patients should be cautioned against driving a motor vehicle or operating hazardous machinery. Since suicide is an inherent risk in depressed patients they should be closely supervised while receiving treatment. Although Adapin has shown effective tranquilizing activity, the possibility of activating or unmasking latent psychotic symptoms should be kept in mind.

Adverse Reactions—Dry mouth, blurred vision and constipation have been reported. Drowsiness has also been observed.

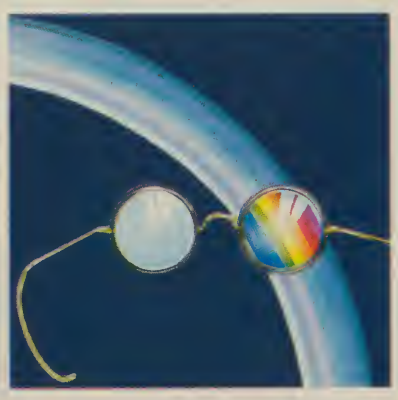
Adverse effects occurring infrequently include extrapyramidal symptoms, gastrointestinal reactions, secretory effects such as sweating, tachycardia and hypotension. Weakness, dizziness, fatigue, weight gain, edema, paresthesias, flushing, chills, tinnitus, photophobia, decreased libido, rash and pruritus may also occur.

Dosage and Administration—In mild to moderate anxiety and/or depression: 10 mg to 25 mg t.i.d. Increase or decrease the dosage according to individual response. **Usual optimum daily dosage is 75 mg to 150 mg** per day, not to exceed 300 mg per day.

Antianxiety effect usually precedes the antidepressant effect by two or three weeks.

How Supplied—Each capsule contains doxepin, as the hydrochloride: 10 mg, 25 mg and 50 mg capsules in bottles of 100 and 1000.

For complete prescribing information please see package insert or PDR.



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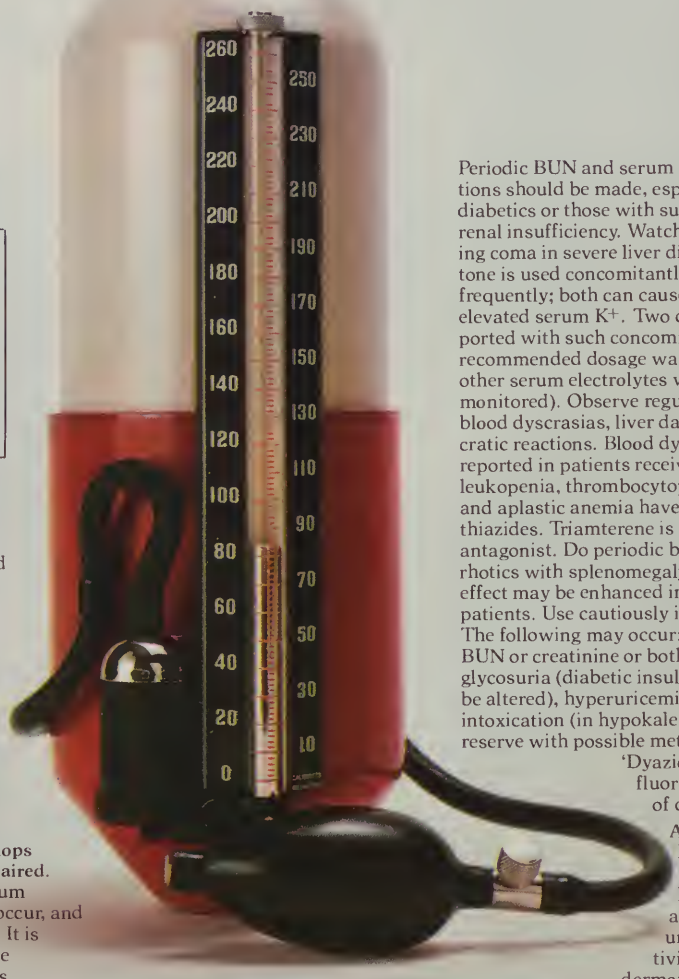
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Each capsule contains 50 mg. of Dyrenium® (triamterene, SK&F Co.) and 25 mg. of hydrochlorothiazide.

MAKES SENSE



Before prescribing, see complete prescribing information in SK&F Co. literature or PDR. A brief summary follows:

* **Warning**
This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

* **Indications:** When the combination represents the dosage determined by titration: Adjunctive therapy in edema associated with congestive heart failure, hepatic cirrhosis, the nephrotic syndrome. Corticosteroid and estrogen-induced edema, idiopathic edema; hypertension, when the potassium sparing action of triamterene is warranted. (See Box Warning.) Routine use of diuretics in healthy pregnant women is inappropriate; they are indicated in pregnancy only when edema is due to pathological causes.

Contraindications: Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K^+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K^+ frequently; both can cause K^+ retention and elevated serum K^+. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

Supplied: Bottles of 100 and 1000 capsules; Single Unit Packages of 100 (intended for institutional use only).

FOR LONG-TERM CONTROL OF HYPERTENSION.* SERUM K^+ AND BUN SHOULD BE CHECKED PERIODICALLY. (SEE WARNINGS SECTION.)

SK&F CO., Carolina, P.R. 00630

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PMS sues to force release of funds to medical board

The Pennsylvania Medical Society January 11 sued the state administration to force release of some $2 million in license fees to the State Board of Medical Education and Licensure so that it can discipline incompetent physicians. Filed in Commonwealth Court, the suit names the Secretary of the Commonwealth, the Commissioner of Professional and Occupational Affairs, the Budget Secretary, the Governor, and the State Board. Plaintiffs are the State Society and George A. Rowland, M.D., of Millville.

Act 111 of 1975, the medical malpractice law, specifically orders the use of physicians' licensing fees by the medical board to fulfill its function of discipline. The Act says the medical board shall hire the necessary investigators, hearing officers, and lawyers to enforce the Medical Practice Act.

Dr. Rowland, chairman of the State Society's Board of Trustees, said, "It is two years since the Act went into effect and absolutely nothing has been done. The state has collected more than $2 million in licensing fees from physicians, but refuses to release the money to the medical board to get the job done. After months of fruitless negotiations, with everybody from the Commissioner of Occupational Affairs to the Attorney General, we had no recourse but to go to Court. Members of the medical board tell us they have asked for their money but as yet don't have it and therefore can't hire the necessary personnel to handle disciplinary procedures."

The suit stipulates that the medical board has received more than 85 complaints against physicians which have not been investigated and processed through hearings. In addition, the board is required by law to investigate all



Dr. Rowland

cases determined to be medical malpractice by the new arbitration system. Nearly 350 complaints have been filed for processing under the new system. Any of these found to have merit must be referred to the medical board for investigation.

Dr. Rowland said, "We are very disappointed that an administration which claims to be consumer oriented has been so derelict in overseeing the licensing boards. The Pennsylvania Medical Society sponsored the amendments giving strong disciplinary powers to the medical board under the new Medical Practice Act and Act 111. Now we intend to see that the state carries out its responsibilities to the citizens of Pennsylvania. We have appealed to the Court to guarantee that the medical board investigates complaints and removes incompetent physicians from practice."

Second opinions urged by HEW

Second opinions on surgery are now being recommended to Medicare beneficiaries by the Department of Health, Education, and Welfare. In November testimony before Congress, HEW Undersecretary Hale Champion announced that the new policy is part of a major departmental effort to combat the problem of unnecessary surgery. Champion will report to Congress within six months on the progress of the new project.

An interim policy instruction to carriers issued in November 1977 by HEW said that, "Second opinions pertaining to potential surgeries are not only covered but are recommended and encouraged" as a means to reduce unnecessary surgery.

Carriers are to pay for claims for patient-initiated second physician opinions pertaining to the medical need for surgery. Payment may be made for patient history, examination, and covered diagnostic services.

In the event that the recommendations of the first and second physicians differ regarding the medical need for surgery, a claim for a patient-initiated third opinion is also reimbursable. Such claims are payable even though the beneficiary has the surgery against the recommendation of the second or third physician.

Carriers are urged to instruct physicians to identify second and third opinions as such on their bills and claim forms, and to devise and use special codes for second opinions so the data may be monitored readily. A major objective of the monitoring will be to determine the effect of second and third physician opinions on the incidence of surgery and the cost of the new project.

At Officers' Conference

N.Y. Times writer to deliver Donaldson Memorial Lecture

Lawrence K. Altman, M.D., F.A.C.P., medical correspondent for *The New York Times*, will deliver the 1978 Donaldson Memorial Lecture at the Society's Officers' Conference April 13. The conference will begin at 1 p.m., Wednesday, April 12, at the Hershey Motor Lodge and Convention Center, and conclude at noon on Thursday, April 13.

Dr. Altman, an award winning journalist, will speak on the subject, "As the Press Sees Us." A graduate of Harvard College and Tufts University School of Medicine, Dr. Altman served as epidemic intelligence officer at the U.S. Public Health Service Center for Disease Control in Atlanta from 1963 to 1966. He completed his residency and a fellowship in internal medicine at the University of Washington Hospital in Seattle in 1969 and joined the *Times* staff that same year.



Dr. Altman

J. Mostyn Davis, M.D., of Shamokin, chairman of the Officers' Conference Committee, will deliver opening remarks at the conference. James R. Sammons, M.D., executive vice president of the American Medical Association will be joined by John F. Rineman, executive vice president of PMS, and Robert Parsons, executive director of the Lehigh County Medical Society, in a panel discussion on "Federation—Working Together."

Other speakers will include James R. Neely, president of the Hospital Association of Pennsylvania, and John Runzer, Esq., and Fred Speaker, Esq., members of the law firm of Pepper, Hamilton & Scheetz, which serves as the Society's legal counsel.

Dr. James H. Boren, nationally known humorist, will speak at Wednesday evening's dinner. His subject will be "Red Tape." John V. Blady, M.D., Society president, will chair the dinner program.

Members of the Officers' Conference Committee are: Dr. Davis; George R. Fisher, M.D., Philadelphia; Paul F. Kase, M.D., Harrisburg; David L. Miller, M.D., New Bethlehem; John P. Mraz, M.D., Erie; Joseph M. Stowell, M.D., Altoona; and Dr. Blady.



THE PENNSYLVANIA MEDICAL SOCIETY sponsored trophies awarded to first place winners in the recent Fifth Annual Pennsylvania Bicentennial Debate. Winners (l. to r.) Shawn Galey and Mary Foertsch from Knoch High School near Pittsburgh, and Steven Postul and Lisa Misteler from Pennsbury High School, Fairless Hills, excelled in arguments to the 1977 national high school debate topic: "Resolved: That the federal government should guarantee comprehensive medical care to all citizens in the United States." The two teams will represent Pennsylvania at the National Bicentennial Debates in Williamsburg, Virginia, February 7-12, 1978.

New specialty group now represents 200,000

At its annual meeting in November the Council of Medical Specialty Societies elected to membership the Society of Nuclear Medicine, located in New York, and the American Academy of Allergy, a Milwaukee-based organization. Their membership, effective January 1, 1978, brings the CMSS total to 22 societies representing more than 200,000 physicians.

The CMSS provides an independent policy forum for specialty societies. It is a co-sponsor of the Coordinating Council on Medical Education and the Liaison Committees on Graduate Medical Education and Continuing Medical Education. While educational activities are its major thrust of involvement, the CMSS is also actively engaged in programs and projects dealing with health care delivery, cost containment, health manpower, and patient safety.

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NEW YORK UNIVERSITY POST-GRADUATE MEDICAL SCHOOL
announces

ADVANCES IN CLINICAL CARDIOLOGY FOR THE PRACTICING PHYSICIAN

Thursday-Saturday
March 30 - April 1, 1978

Fee: $250
8:00 AM-5:00 PM

Course Director: Dr. Kenneth Krauss

This course is specifically designed for primary physicians and internists. The objective is to improve and update basic knowledge and clinical skills required for management of patients with common cardiovascular disease syndromes. Emphasis is on topics of major importance and current interest with an orientation to practical considerations of diagnosis and treatment in the office and hospital setting.

Morning Sessions

Core curriculum review lectures with special emphasis on recent developments of practical clinical importance.

Afternoon Sessions

Part I: *Patient Management Problems* — Case studies illustrating approaches to common clinical problems in office and hospital practice.

Part II: *Demonstration Workshops* — Pacemakers, auscultation update, treatment of hypertension, cardiopulmonary resuscitation, exercise stress testing, echocardiography and Holter monitoring, catheterization laboratory, peripheral vascular examination, management of arrythmias, cardiac rehabilitation center visit.

ADVANCES IN CLINICAL GASTROENTEROLOGY FOR THE PRACTICING PHYSICIAN

Monday-Wednesday
April 10-12, 1978

Fee: $250
8:00 AM to 5:00 PM

Course Director: Dr. Arthur E. Lindner

This course is specifically designed for family physicians and internists who are not gastroenterologists. The objective is to improve and update basic knowledge and clinical skills required for management of patients with common gastrointestinal problems. Emphasis is on topics of major importance and current interest with an orientation to practical considerations of diagnosis and treatment in the office and hospital setting.

Morning Sessions

Core curriculum review lectures with special attention to recent developments of practical clinical importance.

Afternoon Sessions

Part I: *Patient Management Problems* — Case studies illustrating approaches to common clinical problems in office and hospital practice.

Part II: *Clinical Workshops* — Upper Gastrointestinal Endoscopy; Colonoscopy; E.R.C.P.; G.I. Radiology (film interpretation); Small Bowel Biopsy; Esophageal Manometry; Liver Biopsy; Abdominal Ultrasound; Sigmoidoscopy and Management of Common Anorectal Problems; Open Elective Workshop.

ELECTROCARDIOGRAPHY

Monday - Wednesday
April 3 - 5, 1978

Fee: $250
8:00 AM-5:00 PM

Course Director: Dr. George Bear

A practical, intensive review of office electrocardiography stressing basic electrophysiology as an approach to accurate diagnosis. Topics are presented in the context of frequently encountered clinical problems. Presentations include case studies and unknown EKG's for self-assessment evaluation which illustrate the usefulness and limitations of the electrocardiogram as a clinical tool. Common problems that interfere with correct EKG interpretations will be discussed in detail and practical solutions outlined. For internists and general physicians.

Discussions Include:

- The Normal Electrocardiogram
- The Electrocardiogram of Coronary Artery Disease
- Tachyarrhythmias
- Conduction Abnormalities
- Bradyarrhythmias
- Chamber Enlargement
- Drug and Electrolyte Effects
- WPW Syndrome

INTERPRETATION OF CLINICAL LABORATORY DATA FOR PRIMARY PHYSICIANS

Wednesday-Friday
April 19-21, 1978

Fee $250
8:00 AM to 5:00 PM

Course Directors: Drs. Harold S. Kaplan and Paul P. Sher

A practical survey of the laboratory repertoire utilized in the diagnosis and evaluation of patients with diseases commonly encountered in office practice.

Topics include enzymology in cardiovascular disease; evaluation of hyperlipidemias; office examination of urine; thyroid disease, diabetes, and hypoglycemia; laboratory investigation of liver disease; hepatitis update and new developments in bacterial and viral infections. Guidelines for choosing office laboratory procedures are considered.

For information, write or phone: Registration Department, NYU Post-Graduate Medical School, 550 First Avenue, NYC, NY 10016; 212-679-3200, Ext. 4038.

Special Note: Tuition reduced 10% for each additional course. Tuition includes syllabus, continental breakfasts, refreshments, lunches.

Accreditation: All courses approved for AMA Category I credit hours and AAFP prescribed hours.

the management consultant's advisory

LEIF C. BECK, PUBLISHER

This sample issue is a reprint of an actual issue received by more than 400 subscribing physicians and medical office personnel. For subscription details, please see the card attached in this magazine.

ISSUE 77-9, DEC. 1977

A monthly digest of observations and recommmendations arising from the editors' ongoing full-time work as advisors to medical practices on such matters as business systems, personnel management, office facilities, group practice problems, professional corporations, retirement planning and personal finances. The "Action Note" at the end of each item provides the reader with a reminder for prompt action and handy future reference.

SAMPLE

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5 / **Third Party Insurance**	Use a Suspense File for Pending Insurance Claims	10 / **Hiring a Physician**	Prepare Your Practice for a Newly Hired Doctor's Arrival

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RETIREMENT PLANS

1 Earmark Your Plans for Individual Investment Opportunities

Both corporate and Keogh retirement plans offer dramatic financial opportunities, the most significant advantage being the tax-free compounding of investment income over many years. They also present the physicians with difficult investment decisions. If several doctors practicing together have differing views, or expect they might think differently in the future, most retirement plans cannot accommodate the problem—a plan's funds must be invested as a single account.

There is a solution to this problem. A retirement plan may contain provisions specifically permitting each participating employee to direct how his or her account should be invested.* The plan provisions are simple, and an existing plan could be amended to include them at probably no more than $200 of legal fees.

Once a plan permits such "earmarking", each employee could instruct as to investments to the extent of his or her accounts. The annual reports to employees would allocate all these directed transactions, their gains, losses and income to the appropriate accounts. Under the Pension Reform Act ("ERISA"), neither the trustee nor the plan administrator would be liable for the results of an employee's own investment directions.

The opportunity to earmark must be offered to all employees if it is to be offered at all. It cannot be reserved to the physicians and denied to the staff, for example. Nevertheless, it is not unusual for most or all assistants to foresake the opportunity and accept a conservative alternative (perhaps certificates of deposit or a balanced investment fund) available for all amounts not specifically directed.

The one concern is administration, for keeping "earmarked" records is much more time-consuming and costly. We believe the task should be assigned only to an organization actively in that business; and higher fees should be paid for the work. We are aware of some organizations doing good jobs with earmarked retirement plans, a list of which you may receive by writing us with your request.

*Defined benefit plans, requiring actuarial calculations, may not contain such provisions—another reason why we usually advise against them.

ACTION NOTE—If you have or contemplate concerns over your retirement plans being invested as a single fund, consider adding "earmarking" provisions permitting individual investment; but be sure to arrange for expert administration of its accounting complexities.

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PERSONNEL

2 Give Each Employee an Annual "Total Pay Statement"

Many practices, particularly those which are professional corporations, provide some very generous fringe benefits to their staff. The retirement contribution for an assistant might easily be $2,000, for example; while Blue Cross/Blue Shield, group life coverage and medical expense reimbursements could total another $1,000 or more.

Despite the expense, employees are often ignorant of their benefits. Even when they are aware of those programs, however, they rarely seem to appreciate the costs involved. In effect, many staff employees seem to measure their compensation simply by the number of dollars received weekly. The goodwill value of the various fringes has thus been lost.

To help "sell" these benefits, a practice could take one extra step each January. It could prepare a separate "total pay statement" to accompany each employee's W-2 Form. The basic statement can easily be prepared on an office typewriter and duplicated to create as many forms as there are employees. Then each assistant's numbers can be filled in from the wage records, insurance premium notices and pension administrator's information.

The form might read as follows, using imaginary but reasonable numbers:

> "We want you to know the total of all pay and benefits our office provided for you during the year 1977. They are:
>
> | | |
> |---|---|
> | Salary | $ 7,845.40 |
> | Christmas Bonus | 100.00 |
> | Social Security | 464.81 |
> | Unemployment | 84.00 |
> | Blue Cross/Blue Shield | 231.50 |
> | Group Life Insurance | 77.25 |
> | Pension Plan | 476.72 |
> | Profit Sharing Plan | 1,191.81 |
> | Medical/Dental Payments | 234.00 |
> | Total Paid for You | $10,705.49 |
>
> We are delighted that these various benefits could be provided and hope 1978 will be an even better year."

Attaching such a form to the employee's W-2 Form and handing it to her should then impress her that the office offers much more than just a weekly paycheck.

ACTION NOTE—Give your employees annual "total pay statements" along with their yearly tax statements in order to remind them of the valuable fringe benefits they receive.

FINANCIAL MANAGEMENT

3 Write Off and Remove Accounts Receivable on a Specific Schedule

Much because of their professional concern first for patients' health care, physicians are notoriously unsuccessful collectors of their fees. We know, for example, small offices with hundreds of thousands of dollars' face value in delinquent accounts from over the years. These accounts will never be collected and are truly worthless.

Some practices continue to carry the stale accounts with their other patient ledger cards; and their figure for total "accounts receivable outstanding" is tremendous. While not quite so bad, other offices move the very old accounts to separate trays but fail to write them off of their total figures.

We urge practices to routinely and regularly remove delinquent accounts from the active files and reduce the running receivable figures accordingly. These procedures have several important advantages.

First, removal of the account cards reduces the number of items to be handled in the collection process. An office should routinely handle each account as it reaches designated ages, but the task can appear overwhelming if applied to trays of cards far greater than what really require attention. Once an account has passed through the office's collection schedule, it will preumably not receive further office effort and need not clutter the active files any more.

Secondly, however, a physician deserves realistic evaluation of what his accounts receivable really are worth—a figure far below the total unless it is regularly written down. He may require that figure to project his future income, and he might require the information for financial reports even to obtain a mortgage or other bank loan. If several doctors are practicing together, their partnership agreement or corporate documents might call for pay-out of accounts receivable upon death or withdrawal—in which case a mistakenly high figure might cause real dispute in the future.

Adoption of a specific policy on removing and writing off delinquent accounts can best serve a practice and its physician-member(s). We recommend that an account be purged when the last collection letter is sent and the account is turned over to an agency. The staff can then routinely reduce the active ledger tray and make the corresponding bookkeeping write-offs.

ACTION NOTE—Be sure your accounts receivable only include the truly active accounts, removing and writing them off as they complete your office's specific follow-up process.

OFFICE FACILITIES

4 Hinge Your Examining Room Doors the "Wrong" Way

Laying out a new office presents a variety of considerations to the expert. Unfortunately, the people entrusted with the design functions may lack enough experience with medical practice to include some helpful special features. While architects and interior designers are typically hired for the lay-out work, they may be guilty of one complaint.

One little feature might serve as an example. It involves the examining room doors, which we recommend be hinged on the opposite side from the nearest partition wall. This hinging is contrary to the usual arrangement for doors, both in residential and commercial construction.

When a door hinges the "usual" way—a person entering the room will have a sight line into the center of the room as he opens the door. He can thus see into the room quite early as he is still entering. In medical offices, a mistaken entry and look into an occupied examining room can cause real embarrassment for patient, intruder and staff.

Hinging a door the "wrong" way, so it will swing into the center of the room, can minimize the problem somewhat. The sight line will be towards the partition wall as the door itself swings in. A person's view will still be blocked by the door itself until it is wide open—he cannot see into much of the room so soon. A patient disrobing or being examined in a "wrongly" hinged room will thus have a greater opportunity to speak out before being seen by the intruder.

ACTION NOTE—Consider little medical practice amenities, not possibly known to architects and designers, when arranging your new office. Remember one of these—setting examining room hinges differently than usual to help foster patient privacy.

SAMPLE

THIRD PARTY INSURANCE

5 Use a Suspense File for Pending Insurance Claims

While business offices usually and properly prepare carbon or photo copies of each Blue Shield, Medicare, commercial, etc. insurance form they prepare, there is wide divergence in how those copies should then be filed and used. Some offices place the copies in the patients' medical charts, the absolute worst choice. Other offices place the copies in a separate file drawer arranged alphabetically by patient name.

We recommend a different approach using a file drawer and chronological date dividers. The drawer would serve as a "suspense file" for handy follow-up reference to the claims most requiring attention—the oldest ones.

When an insurance claim form is completed and mailed out, the secretary should pencil onto that patient's ledger card the date it is sent. The copy of the form should be placed to the rear of the suspense file, at the day's date. Then as claims are paid, the copies of those paid forms should be removed—leaving the oldest unpaid ones towards the front.

Any secretary could under this system easily go to the suspense file and pull the oldest unpaid claim forms for follow-up inquiry. She might call an insurance company to see if a claim was received and its status; or she might call a patient to see if he or she received and signed the original as requested. Whatever the need, the job is made easier when those items most requiring attention easily present themselves. This is the advantage of the chronological filing.

Some employees object that alphabetical filing of the forms makes it easier to locate the copies when patients telephone with questions. We find, however, that assistants routinely first check to patients' ledger cards. Since the insurance filing dates would appear on those cards, cross reference to the chronological suspense file is no particular hardship.

ACTION NOTE—File the carbon or photo copies of your third party insurance forms chronologically according to the date each form is mailed out, thus creating the best opportunity for efficient follow-up.

EQUIPMENT

6 How to Assure Obtaining Investment Tax Credits Before Year-end

Federal income taxes are costly and often frustrating to physicians, as to many other taxpayers, but one provision offers some real tax-saving opportunities. It is the "investment tax credit" which essentially creates a dollar-for-dollar tax saving up to 10% of the cost of office equipment. On the purchase of a new $4,000 EKG machine for example, a doctor's Federal income tax would be reduced by $400.

As a physician approaches the end of 1977, he should consider if there are any items of practice equipment or furnishings that soon should be obtained. If so, the investment credit tax saving would apply immediately to his 1977 income tax return* upon prompt purchase. The saving opportunity may be considerable enough to warrant hurrying up with that purchase.

One must, however, be careful to assure 1977 entitlement to the credit. The tax law requires that the item be "placed in service" before the year has ended. Merely receiving delivery of an item this year does not necessarily satisfy those words. However, using it even one time in the practice would be equivalent to placing it in service, thus requiring that the item actually be pressed into use.

The credit will apply to an item placed in service whether or not it has yet been paid for, so that receiving and paying the bill is not as pressing as the use. As to an item obtained late in December, it would be more helpful to document its first use —perhaps a patient billing or someone's signature as witness—than even to make payment. Particularly if a "big ticket" item, like X-ray machinery, is involved this precaution can be very important in case of later tax audit.

*The credit, would, of course, apply for a corporation's fiscal year if the item is instead purchased by or leased to a corporation—that year may or may not conform to the December 31 calendar year discussed in the article. All but very old partnerships are almost certainly on the calendar year basis.

ACTION NOTE—Accelerate to this year any equipment purchases you plan on making soon, but have good proof that any such items are "placed in service" before the year ends.

BILLING SYSTEMS

7 How to Handle Monthly Computer Summary Print-outs

Computer billing services offer attractive arguments in their favor, and despite our usual skepticism* we recognize that some of the arguments are valid. On one point, however, we have real mixed feelings.

Computer services usually provide reams of information at the end of each month. The information might include each open account's status, an aging of accounts receivable, breakdowns of how many times each procedure has been performed and so on. On top of this information, there will usually be one or two pages of "summary" intended to allow the manager and/or doctor(s) to see briefly the important totals.

While the summary sheet should serve as a valuable management tool, it is often not so used by physicians. We are told that the sheets don't seem "readable" in their computer print, that the items don't quite report what the doctor(s) wanted to know and that the items aren't changed as the doctors' concerns change.

Because of these objections, we recommend one rule for application to practices having computer billing services; develop your own one-page monthly information sheet for management use. The bookkeeper and/or manager should enter (perhaps in handwriting) the appropriate numbers from the computer summary, adding whatever other items or comments are most of interest to the doctors each month.

Such a "less fancy", personalized monthly sheet has maximum opportunity to be studied critically. In turn, sensible managment decisions are most likely to result from conscientious and regular review of the information. The computer service might be valuable in collecting that information, but its translation to an internally designed, more personalized statement will help the numbers be more useful.

*See "Strict Rules to Observe in Considering a Computer Billing Service", Issue #77-4, item 2.

ACTION NOTE—If you are on a computer billing service, design your own informal monthly statement for presentation of the service's summary items; don't just rely on the computer summary sheets.

This sample issue is a reprint of an actual issue received by more than 400 subscribing physicians and medical office personnel. For subscription details, please see the card attached in this magazine.

PROFESSIONAL CORPORATIONS

8 Some Reasons for Paying Your Business Expenses Personally

Most professional corporation arrangements call for business expenses to be paid by the corporate employer on behalf of its physician-employee. One reason usually given is greater accounting convenience since all business deductions would run through a single checkbook. There is also an emotional feeling that the doctor is not himself "paying" expenses which are taken care of by his corporation—though this is illusory. And some tax advisors suggest, with little real truth, that the deductions will more likely escape tax review on the corporation's return than the doctor's personal tax return.

There are, however, some very appealing reasons favoring the opposite arrangement. It would call for increasing a physician's salary but requiring him to pay his professional expenses personally. The expense payments would be just as deductible on his personal tax return so long as the corporate documents require his payment as part of his employment.

For one thing, the personal payment would avoid the possible double tax effect of having those expenses disallowed upon an audit of the corporation's tax return as "preferred dividends" upon an audit of the corporation's tax return.

There is another very fascinating advantage to personal payment. Suppose a doctor on a $60,000 salary has business expenses of $10,000. By increasing his salary to $70,000 and paying those expenses himself, his corporation's maximum retirement plan contribution could be increased. The allowable contribution is, of course, a function of his salary.

Furthermore, a high income physician could reduce his cost of contributing for his staff by this device. Suppose the above-described doctor wishes to contribute only $12,000 per year for his own retirement. At that level (on a non-integrated money purchase pension plan), he would be able to reduce the corporate contribution for his staff by 3% of their salaries. The reason, of course, would be that a $12,000 contribution for him would change from 20% of salary to about 17%. Even malpractice insurance premiums might be paid personally. Surgeons might thus dramatically increase their salaries and reap the retirement plan savings. The approach is appealing enough to merit our suggested switch in some corporate arrangements.

ACTION NOTE—Consider increasing your corporate salary and paying many business expenses personally; it might result in retirement plan savings.

TELEPHONE

9 Should Your Patients Call the Office for Their Lab or X-Ray Results?

We continue to be concerned over so many practices' telephone problems. Interminable busy signals and over-harrassed receptionists are two common complaints. Any ideas which can reduce the telephone load should be extremely valuable.

In tackling the phone problems, one important step is to evaluate the types of calls which clog the lines. For many practices, particularly in primary care, a great number of the calls are patients' inquiries about their lab work and/or X-rays. The doctor or nurse might even have instructed the patients to call and obtain their results!

These calls simply add to the phone burden. Worse still, they often come at the wrong time—perhaps when the receptionist is at her busiest, when the results have not yet been received or when the assistant having the information is unavailable. Those ill-timed calls create a worse result of later phone calls for the same purpose.

We recommend an office's adoption of an explicitly stated rule as to lab and X-ray results: patients cannot phone in for their results, but the office will telephone the patients. The appropriate assistant(s) can then collect all the necessary materials and make a batch of calls reporting results when free to do so. The incoming lines and the receptionist would be spared innumerable calls and the assistant could dispose of the reporting needs more efficiently.

A rule as to lab and/or X-ray results should be adopted and made known to all patients. It ought to be a specific entry in a "Patient Information Booklet." If there is concern that a test result might be lost and hence not reported, the rule can be modified so patients are instructed to call if they have not been contacted in, say, two days.

Some people have objected that our approach would be costly if many toll telephone calls must be made. We believe, however, that the cost savings in handling the calls when employees can most effectively do so will far outweigh the telephone toll charges.

ACTION NOTE—To reduce the strain on your receptionist and your telephone lines, adopt a policy whereby patients are not to call in for their lab or X-ray results; have your office call them out instead.

HIRING A PHYSICIAN

10 Prepare Your Practice for a Newly Hired Doctor's Arrival

A practice should start planning for the addition of a new doctor several months before he actually arrives. Seeking his admission to the necessary hospital staffs is, of course, well understood but other steps should also be taken.

For example, malpractice insurance coverage will have to be obtained effective the day the doctor first sees patients. This may present some complications in view of insurers' present attitudes. A senior physician may even be forced to switch his own insurance coverage if his insurer will neither cover the new man nor insure the senior against liability for his new associate's possible malpractice. The matter should therefore, be pursued promptly after the employment agreement has been entered.

Scheduling patients may also require several months of lead time: effective use of the new doctor calls for him to be booked as fully as possible the first day he joins the practice. A policy of scheduling new patients, and perhaps existing patients, must be decided upon so the receptionist will know how to arrange appointments. This may call for a new appointment book to be designed and put into effect some months in advance.

Many related in-office decisions are also required: what shall the new office hours be? What space shall the new doctor occupy? What changes in aides' responsibilities must be made? What additional equipment and supplies will be needed? How, when and to whom shall announcements be mailed? How should existing patients be notified? What should the new doctor's fee schedule be and how might the joint practice change its fees? What third-party insurers need be notified?

The questions are endless, but they will best be dealt with by the deliberate attention of the doctors involved. If they are ignored or delayed, the new doctor's arrival will result in an unnecessarily rough transition stage.*

*From "The Physician's Office", by Leif C. Beck, published by Excerpts Medica (1977), pp. 134-135.

ACTION NOTE—If a newly hired physician will join your practice next July, begin soon to plan the details of his arrival. Arrange things so he can fit into your work patterns immediately upon his arrival.

Philadelphia, Allegheny Societies install new officers

Members of the Allegheny and Philadelphia County Medical Societies met recently at their respective annual dinners to inaugurate officers for 1978.

Joseph V. Caliguiri, M.D., was installed as the 113th president of the Allegheny County Medical Society on January 14. Other physicians assuming office with Dr. Caliguiri are president elect Howard A. Mermelstein, M.D.; first vice president Harold E. Swenson, M.D.; secretary Ralph Gaudio, M.D.; and treasurer Robert M. Laughlin, M.D.

The Philadelphia County Medical Society installed its 117th president, John Helwig, Jr., M.D., on January 18. Serving with Dr. Helwig are Robert S. Pressman, M.D., president elect; Sidney O. Krasnoff, M.D., vice president; Edward J. Resnick, M.D., secretary; and Peter A. Theodos, M.D., treasurer.

Blue Cross, Shield national associations merge

The Blue Cross and Blue Shield Associations have announced that, effective January 1, 1978, they will operate under one chief executive and consolidate staffs in order to promote greater efficiency and economy within the organizations.

Named to head the newly merged national associations is Blue Cross Association president Walter J. McNerney. Blue Shield president William E. Ryan was named senior executive vice president.

The two associations will retain their current boards of directors, each accountable to its respective members. The boards will meet jointly on matters of mutual interest and separately on items of specific interest to their member plans.

Conjoint meeting planned

The Philadelphia Academy of Surgery will sponsor a conjoint meeting of the academy and the New York Surgical Society on March 15, 1978 at the Philadelphia College of Physicians. Members of each group will present a series of scientific papers on recent surgical advances. Philadelphia Academy members plan a second conjoint meeting, this with the Baltimore Academy of Surgery, on April 13, 1978 in Baltimore.

Thoracic surgeons elect

At its fifteenth annual meeting in September, the Pennsylvania Association for Thoracic Surgery elected eight thoracic surgeons to active membership. The meeting was conducted by R. Robert Tyson, M.D., Philadelphia, who was succeeded in the presidency by John A. Waldhausen, M.D., Hershey. James L. Harrison, M.D., Williamsport, was elected vice president while Joseph C. Donnelly, Jr., M.D., and Horace MacVaugh III, M.D., both of Philadelphia, were reelected secretary and treasurer, respectively.

State boards hold first joint meeting

In a first-of-its-kind meeting, representatives of the State Board of Medical Education and Licensure, the State Board of Osteopathic Examiners, and the State Board of Podiatry Examiners assembled on December 8 in Harrisburg to discuss issues of common concern.

Medical Board chairman Richard C. Lyons, M.D., said the joint meeting was an expression that the boards can and want to work together to resolve common problems and improve health care delivery in Pennsylvania.

Topics of discussion included: the supervision of physicians' assistants; the possibility of summary suspension powers being granted to the boards; the signing of drug orders in institutions; and the question of who should be permitted to practice acupuncture.

Physician's license revoked by State Board

The State Board of Medical Education and Licensure has revoked the license of Almon C. Stabler, M.D., Flourtown, effective November 23. Dr. Stabler has indicated he will appeal the revocation to Commonwealth Court.

The Board found that Dr. Stabler prescribed controlled substances to persons without following treatment practices conforming to the standards of acceptable and prevailing medical practice.

According to testimony presented to the Board during a formal hearing, Dr. Stabler was found to have prescribed a controlled substance without giving the patient a physical examination.

The Board ruled that Dr. Stabler's actions constituted unprofessional conduct.

Co-op opens right of purchase to all PMS members

The Pennsylvania Medical Cooperative has announced that any PMS member may now purchase low cost medical supplies from the Co-op. The new plan, approved by the PMS Board at its November meeting, will open a potential market of 8,000 new physician customers.

To kick off its new promotion, the Co-op is mailing product catalogs to all PMS members. The catalog contains more than 2,000 items with product description and prices.

"The Co-op is thriving," says Bob Weiser, acting manager. "We now have a steady membership which purchases supplies regularly. But if we're to grow, we must increase sales by reaching new markets."

Until now, the market consisted of some 2,000 physicians who paid a one-time membership fee in order to purchase Co-op supplies. This fee was used to start the business and build inventory. Under the new plan, any PMS member will be able to purchase supplies from the Co-op without paying the membership fee. However, members who have paid the initial fee will reap extra benefits.

"Co-op members will benefit the most from the plan," says Weiser. "They'll start out saving an additional 5 percent on all their purchases, and as sales increase, prices will go down even more. They'll also benefit from monthly specials which will be offered to members only."

The Co-op began in October 1975. Robert Davis, M.D., Cumberland County, president of the Cooperative, was one of the original planners and has watched it grow from infancy.

"There were some problems in the beginning, there's no doubt about it. It's hard for a physician to break old buying habits. But I think the Co-op can fulfill a great need for any physician. After all, we're not in business to make money—only to provide low cost office supplies and good service," says Dr. Davis.

During its first full year of operation, Co-op sales totaled $501,000. In less than one year sales increased 30 percent. Weiser estimates that Co-op members as a group saved in excess of $100,000 on their puchases in 1977.

"The fact that we've managed to make this concept work over the past two years is quite an achievement when you consider the tremendously hostile environment we ran into," Weiser says. "The competition did everything they could to put us out of business, but we've proven we can survive."

The Co-op's major competitors





THE COOPERATIVE'S annual report to the 1977 Annual Meeting of the House of Delegates was presented by Dr. Davis, at the top. Weiser and Marcia Dutton review orders at the bottom. To the right in the warehouse, H. Edward Dobson and Weiser, above, check a shipment. Robert D. Shreve, Jr., below, discusses new merchandise with Weiser.

are the big medical supply houses and mail order businesses which vie for the physician's business. But the Co-op does have one big advantage over both of them.

The Co-op is a non-profit company, which is the main reason why it is able to keep prices low. Once overhead costs are met, the rest of the income goes back to its customers in lower prices.

"By purchasing through the Co-op, you eliminate the salesman," says Weiser. "Salesmen take up your time and your staff's time. They cost money, too, because they have to be paid commission. This extra cost is added to your purchase price."

The Cooperative is the only supply house in the country which sells only to physicians. Other medical supply companies are geared toward hospitals and nursing homes which buy in large quantities.





"The Co-op sells just about everything a physician needs for his office, examining room and reception room," says Weiser. "That includes disposable medical supplies, diagnostic equipment and supplies, an extensive line of generic pharmaceuticals, paper products, cleaning products, and even small items like office supplies."

Almost every one of the 2,000 products in the Co-op's inventory has been selected by the Product Selection Committee of doctors. They examine new products and review the performance of existing ones.

The Co-op carries brand name products as well as products of lesser known manufacturers and guarantees all products. Refunds or exchanges can be made within 60 days of the purchase.

The Co-op has built a solid reputation for fast service and reliability. Orders are processed and shipped in 24 hours—less time for "rush" jobs. Three shipping companies are used to ensure the best possible delivery time to all parts of the state.

"Phone orders are the quickest way to get your order moving. If a doctor sees an item he wants in the catalog, all he has to do is pick up his phone and call. If the call is made before noon, chances are we can have the order out that same day," says Weiser.

The Pennsylvania Medical Cooperative is located at 3617B Simpson Ferry Road, Camp Hill, PA 17011. Orders can be telephoned to (717) 761-8215.

"I want the Pennsylvania physician to realize that he is in a unique situation," says Weiser. "The Co-op is the only physician-owned and operated medical cooperative in the country! We're only in business to serve the physician and save him money. I can't emphasize that enough."

Licensing boards flounder in due process decision wake

Fred Speaker, Esq.

Legal representation of licensing boards, such as the State Board of Medical Education and Licensure, remains under a disabling cloud as a result of a recent decision by the Commonwealth Court.

In the case of *Commonwealth, Department of State v. Chairman,*[1] the State Board of Podiatry Examiners notified three podiatrists that it would conduct a hearing to determine whether their licenses should be revoked because of billing irregularities and overzealous care. The Board's solicitor presented the case for the Commonwealth, apparently ruled on evidence, gave advice to Board members, and was instrumental in drafting the Board's adjudication and order after it decided to suspend the licenses.

Two of the podiatrists appealed on the basis of alleged denial of procedural due process caused by the commingling of the Commonwealth's judicial and prosecutorial functions. The Court held:

> The actions of the Board's solicitor in the instant case fall squarely within the activity proscribed. . . . That the solicitor was allowed to advise the tribunal with respect to ongoing proceedings created an impermissible appearance of possible prejudice.[2]

Thereupon the case was returned to the Board "for a hearing in which the separation of judicial and prosecutional functions will be strictly observed."[3]

The significance of this opinion is that it continues an attack on regular Commonwealth practice. Mixing judicial and prosecutorial functions of hearing boards, either by giving one individual those dual responsibilities or by having two individuals who are administratively tied together—such as a general counsel and a staff attorney—perform those functions, remains a common practice.

The Pennsylvania Supreme Court currently is faced with a decision that should go a long way toward a definitive, general statement of the law on this subject. The Commonwealth Court, in *Commonwealth, Department of Insurance v. American Banker's Insurance Co. of Florida,*[4] had reversed the determination of the Insurance Commissioner based on a hearing in which the prosecutor was the direct subordinate of the hearing examiner. Commonwealth Court held that the proceedings were susceptible of prejudice, and the Commonwealth appealed.

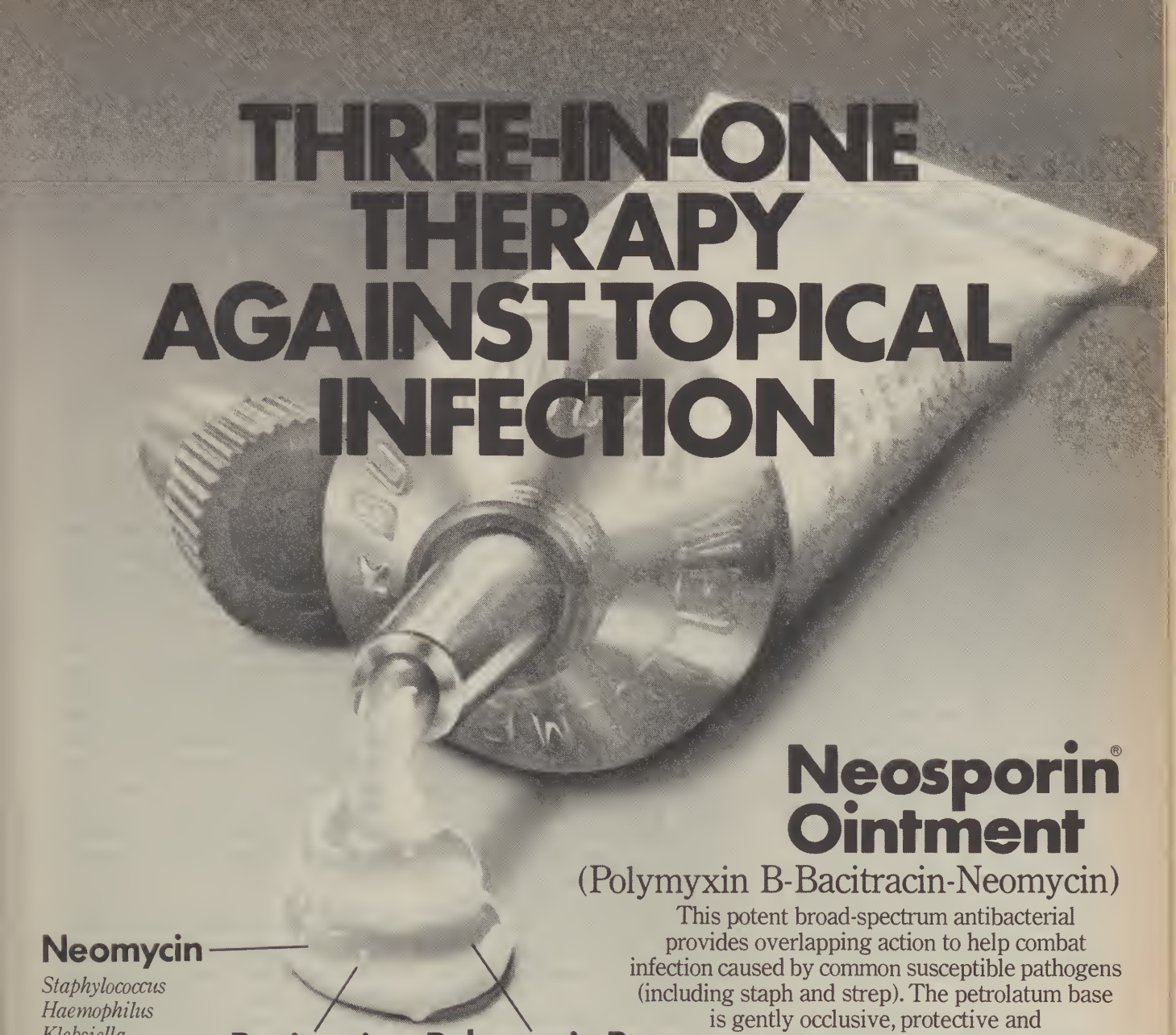
Mr. Speaker is a member of the law firm of Pepper, Hamilton & Scheetz, which serves as the Society's legal counsel.

A line of Pennsylvania cases in the Seventies has established that the courts will not tolerate the situation in which a lawyer represents a party appearing before the board and also gives advice to the board during the hearing or during its decision-making process.[5] The cases have also established that when two attorneys are involved—one representing the prosecutorial aspects of the case and the other giving advice to the board—the commingling may or may not be allowed. In *State Board of Medical Education and Licensure v. Grumbles,*[6] the Commonwealth Court indicated that, when one attorney represents a party before a tribunal and another attorney from the same office or department advises that tribunal, the combination is impermissible. However, the division of the functions between two distinct administrative entities with no direct affiliation,[7] or the situation in which there was no commingling during the crucial fact-finding stage of the proceedings,[8] is supportable.

The Pennsylvania Supreme Court's decision in the American Banker's case may sketch more clearly the proper division between allowable and impermissible procedures in representing the licensing boards. In the meantime, physicians should be aware of the possible continued disability that currently afflicts the boards.

1/ *377 A.2d 1022 (Commw. Ct. 1977).*
2/ Id. *at 1024.*
3/ Ibid.
4/ *26 Commw. Ct. 189, 363 A.2d 874 (1976).*
5/ See Horn v. Township of Hilltown, *461 Pa. 745, 337 A.2d 858 (1975);* English v. North East Board of Education, *22 Commw. Ct. 240, 348 A.2d 494 (1975); In Re: Appeal of Feldman, 21 Commw. Ct. 451, 346 A.2d 895 (1975);* Donnon v. Downington Civil Service Commission, *3 Commw. Ct. 366, 283 A.2d 92 (1971).*
6/ *22 Commw. Ct. 74, 347 A.2d 782 (1975).*
7/ State Dental Council and Exam. Bd. v. Pollock, *457 Pa. 264, 318 A.2d 910 (1974).*
8/ Pennsylvania Human Relations Commission v. Thorp. Reed & Armstrong, *25 Commw. Ct. 295, 361 A.2d 497 (1976).*

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WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.

practice management

Corporation 'fringes' should include health care

Leif C. Beck, LL.B., C.P.B.C.
Vasilios J. Kalogredis, J.D.

While the primary (and often sole) reason for practicing as a professional corporation is often the retirement plan opportunities, the majority of other fringe benefits are frequently confused or overlooked. Many of these other fringes relate to health protection for the physician and his family, so they are of real planning concern even beyond the usual tax-saving considerations. The fringes relating to health care are health insurance, a medical and dental expense plan, and disability insurance.

As an opportunity for incorporated physicians to review their own arrangements, let us explore some of our observations about these three fringes.

Health insurance

Health insurance is so basic that no doctor should be without it, and only rarely do we see one without some sort of coverage. Nevertheless, many physicians are poorly insured against serious illness.

Some doctors have only the basic health insurance provided by Blue Cross/Blue Shield or its equivalent. Many of those basic policies fail to provide sufficient coverage against catastrophic medical expenses—the risk for which a physician most needs protection. Many "Blue" plans, even some called "major medical," are alarmingly deficient in case of huge medical care costs.

We strongly believe that each physician must seek and obtain health insurance coverage that provides virtually unlimited maximums. Some group programs, such as the AMA's "excess major medical" policy, seem to offer this protection. Many plans that we see, however, do not.

A second concern is for the quality of health insurance protection. A variety of health plans offered through smaller medical societies, alumni groups, and the like are appealing because they provide apparently good coverage at bargain premium rates. This may be particularly attractive because other medical policies are becoming so expensive.

When it comes to health insurance, the old adage, "You get what you pay for" holds true. There is simply no way in which one insurance company can offer coverage equal to that of another company at a dramatically lower price. The actuarial likelihoods of illness, injury, and soaring health care costs cut across all classes of people and thus eliminate the possibility of premium variations.

This truism has led to a near impossibility—the purchase of an individual, commercial health insurance policy. Each company offering such individual insurance has raised rates and dropped out of the market, leading to the problem of where to obtain equivalent protection.

Group health insurance, purchased by a corporation for all its regular employes, is often the best answer.[1] Excellent quality coverage, often with unlimited maximum benefits, has become a striking feature of those insurance companies that heavily promote group programs.

In many cases, such health coverage can be obtained only as part of a group term life insurance program through that insurer. Purchasing the life insurance may, however, be a cheap "price" to pay for the medical plan—and the group term life coverage may prove to be valuable. Many companies require low limits of life insurance, perhaps only $10,000 per doctor and less for staff, so that its purchase is a moderate way to qualify for the health insurance program.

The greatest "cost" of obtaining health insurance through a group term life program may be the requirement to cover all full-time employes. Unless most assistants have families covered by other sources, this cost could be substantial. Nevertheless, health insurance is fast becoming the single most important benefit required by employes, and its offer may be proper and/or necessary.

Various approaches can be taken to contain the corporation's costs of providing health coverage. Premium payments may be limited to a fixed percentage of each employe's salary as part of an overall medical/dental expense plan so that expenditures above the limit are paid by the employe. The physician's far higher

The authors are the principal consultants of Management Consulting for Professionals, Inc., Bala Cynwyd.

[1]Group insurance can also be obtained by a partnership or unincorporated solo practice, although this possibility is often overlooked.

salary would provide his full premium cost, but the same percentage of other salaries would require employe copayment.

Most group insurers permit exclusion of some employes. This permits exclusion of some or all married assistants whose spouses already have family health coverage, while the lower cost of providing single persons' coverage to the remaining unmarried assistants is made acceptable. As long as the exclusions are determined in a consistent, nonjudgmental way, the coverage and tax results should be as desired.

Professional corporation status offers the intangible advantage of forcing doctors to focus on their health insurance programs. The premiums paid under a proper plan are tax deductible by a physician's corporation and are not taxed to him personally. This advantage does not extend to partnerships or unincorporated solo practices.

The tax-favored fringe benefit opportunity does not, however, assure a sensible decision as to the medical insurance actually obtained. Each physician must critically review his coverage to see that it is as good as he requires and deserves.

Medical/dental expenses

A plan by which each qualifying employe's medical, dental, optical, and prescription drug expenses (and those of his immediate family) are paid by the employer is a unique advantage of professional incorporation. For the physician these expenses are usually not tax deductible, but they will be tax-favored if paid through the corporate plan. This opportunity should not be ignored.

Many professional corporations have not adopted such plans for dubious reasons. Some doctors believe that a plan must cover all full-time employes (physicians and staff), which is simply not true. Tax law requires that a medical/dental expense plan be adopted "for employes" without specifying which employes and to what extent. While the requirement makes it useful to cover more than just the physician-shareholder(s), considerable leeway remains.

A corporation having one or more physicians who are not shareholders could, for example, provide coverage to all its physicians—a class broader than its stockholders. Coverage for a young doctor joining a group can usually result in an informal "trade-off" by setting his salary with the medical/dental benefit in mind. Similarly, a group might have an office manager, key senior assistant(s), or physician's assistant(s) who should be extended the benefit without covering all other staff.

Another approach is to cover all full-time employes but to limit the amount which may be spent for each employe each year. A limit of 5 percent of his salary would, for example, provide only $364 of payments for a $140 per week assistant, but it would permit payments up to $3,000 for a physician who earns $60,000. Furthermore, if Blue Cross/Blue Shield or other medical insurance is provided each employe requiring it (as discussed above), the plan might include those premiums as part of each employe's expenses covered by the 5 percent plan, thus further reducing the cost for staff while leaving leeway to cover the physicians' expected uninsured expenses.

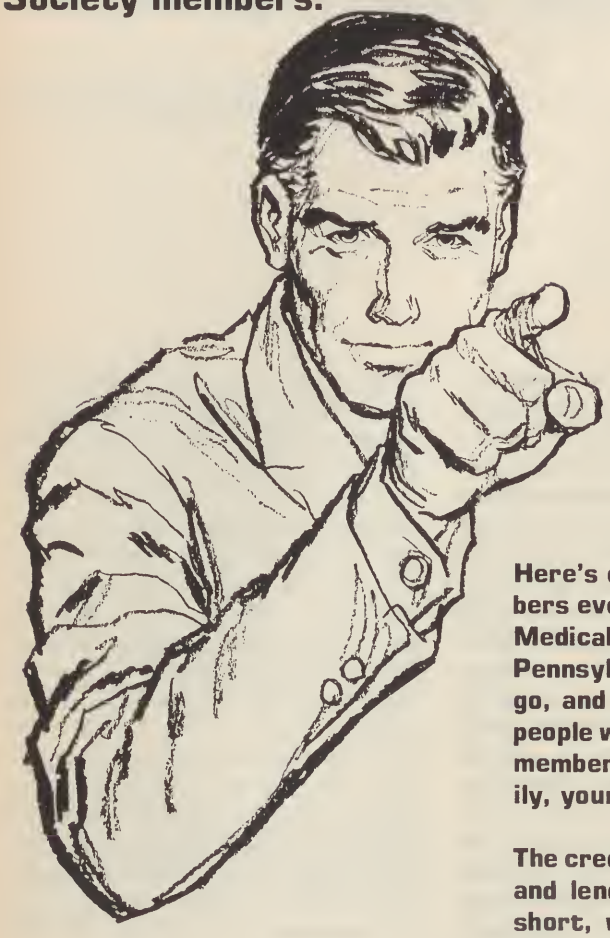
A variety of other approaches is possible. Given these cost-saving possibilities, the incorporated physician should find a medical/dental plan extremely useful. And to the extent that it bestows some benefit on the practice's assistants, the employe relations "goodwill" should be worth the cost.

"Professional corporation status offers the intangible advantage of forcing physicians to focus on their health insurance programs."

Other incorporated groups have rejected medical/dental plans for a different, but usually unsound, reason. They believe that the variations in expense payments for each physician-member will interfere with their existing approach to dividing practice income. An equal partner with no minor children and only minimal annual expenses will, for example, feel shortchanged if his other partner has three children undergoing orthodontic treatment.

In some cases, groups should simply recognize year-to-year variations as

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acceptable burdens. The medical/dental expense payments would thus be treated as true practice expenses which are likely to even out over the years. A doctor whose family incurs few expenses one year might have them another year, and the practice will assume them for whichever doctor "gets hit." As long as the plan contains a maximum limit acceptable to all doctors, this may be satisfactory.

In other cases, however, the possible variations will concern the members enough that they cannot be ignored. The group might then keep an informal record of each doctor's expense level; and in determining any general bonuses and/or salaries in succeeding years, the variations could be taken into account. While this approach should not be formalized, many groups have the faith and flexibility to consider the medical/dental experience among their compensation factors.

At any rate, the opportunity should not be ignored. An incorporated solo physician in the 50 percent tax bracket who has $2,000 of medical/dental expenses presents an oversimplified but common example. Setting his salary at $2,000 less so the amount can instead be used to pay his expenses will save him $1,000 of tax at no loss of useable cash. The objections discussed above should not overshadow that savings opportunity.

Disability insurance

While some doctors are "over-insured" when it comes to life insurance, very few have a sufficient amount or quality of disability (income continuation) insurance coverage. Statistics show that a person who is 40 is three times more likely to suffer a long-term disability than he is to die in that year. Thus, disability insurance deserves far more emphasis than it receives.

As with health insurance, disability coverage offers some choices. The physician may buy privately sold, "non-cancellable" insurance at a fairly high premium (which rate will not increase over the years); or he may purchase inexpensive "association group" coverage through his medical societies, alumni associations, etc.

Each type of coverage presents advantages and disadvantages. The association group policies run the risk of having the master contract cancelled, in which case each member may find himself without his insurance. If a member were then uninsurable he could be unable to obtain substitute coverage from another company—a very serious potential risk.

This cancellation risk is important enough that doctors should avoid purchasing the insurance through small group plans. Large associations like the AMA and larger state societies will have the "clout" to prevent cancellation or require that a successor insurance company cover all previously insured members. Smaller specialty societies, county associations, and alumni groups are not likely to have enough members to wield this type of leverage. Thus, purchase of "association group" coverage should be made only through very large medical societies.

Even so, the low price of association group coverage implies lower quality coverage. The test of disability insurance should not be how cheap it is but whether the company will pay quickly and willingly upon a policyholder's illness. This will vary among companies, and the lower price of mass coverage usually carries with it a lesser certainty of collecting.

The advantage of the more expensive, private "non-cancellable" insurance is its excellent quality. Three or four companies have particularly outstanding reputations for realistic policy definitions, generous provisions concerning partial return to work, and responsive handling of claims. In our view, a physician should have this coverage despite its higher cost.

We favor a physician's "mixing" in his disability portfolio some expensive non-cancellable coverage with some cheaper (but good) association policies. The expensive policy or policies would be his basic, essential protection, while the group insurance would enable him to augment it at an acceptable cost. If he prospers, and especially if his retirement plan(s) grows sufficiently to give him greater financial security, he could drop the association policies as their rates increase with his age. The basic "non-can" protection would not increase in cost as he grows older.

A professional corporation may adopt a plan to carry disability insurance for its employes. This approach presents a tax-saving advantage for an incorporated doctor, i.e., the deductible corporate payment of his premiums for his benefit. But it also presents a potential disadvantage, for any benefits he receives upon disability will be taxed to him as income if the policies were carried or financed by his employer corporation.[2] They would not be taxable to him if he paid the premiums personally.

"We favor a physician's 'mixing' in his disability portfolio some expensive non-cancellable coverage with some cheaper association policies."

We often recommend a mixing of corporate and personal premium payment to best tax advantage. The corporation might carry the expensive "non-can" policy, thus obtaining tax deductibility for the major portion of a doctor's total disability insurance costs. In case of illness, the income tax on the policy's monthly benefits would probably not be at such high rates, for the benefits would probably be the only major source of taxable income after just a few months' absence. In contrast, the doctor's personal payment of the cheaper association premiums is not too serious from a tax standpoint, but in case of illness the benefits will not pile up as further taxable income (at higher tax rates) on top of the other taxable benefits.

We strongly oppose corporate purchase and ownership of disability in-

[2]A popular "gimmick" has been discussed, but we have little faith in it. The doctor personally pays the premiums during a year and, if he does not become disabled, the corporation reimburses him at the end of the year. While it is suggested that receipt of disability benefits during the year would thus be non-taxable because not employer-provided, we are convinced the argument will not stand IRS scrutiny. Various accountants have told us they could not ethically avoid reporting the benefits as taxable in such circumstances, and we agree with them.

surance on a uniform basis for each physician. It seems to be a favorite insurance approach, designed partly to assure that future physician-members must similarly be covered through the same agent. Instead, a corporation should adopt a plan which allows it to pay directly (or reimburse) a doctor's premiums on whatever policies he wishes to carry. Each doctor will thus have the freedom and flexibility to obtain the insurance which best suits his own financial circumstances, for there is no reason to assume that those circumstances will always be similar for different members of the same group.

A corporate plan might express its undertaking to pay directly or reimburse each physician-employe's disability insurance premiums up to some specific percentage of his basic salary. For a $60,000 per year doctor, a 2 or 3 percent plan would permit fairly ample flexibility to run one or two expensive "non-cancellable" policies through the tax-favored route. The cheaper policies could still be paid personally by the doctor and not be involved in the corporate plan.

As with medical/dental expense plans, disability insurance (termed accident and health insurance in the tax code) must also be under a plan "for employes." Providing it only for the physician-shareholder(s) presents the same tax risks, and broadening the plan's coverage to other employes would be very helpful.

Some doctors actually provide shorter term disability coverage for all full-time staff as a self-serving but valuable fringe benefit. The cost of such coverage (sold through some medical societies under the sexist term "Girl Friday insurance") is quite low, and yet it can justify reducing the length of time a practice will provide sick pay in case of an assistant's illness. In one example, we found the insurance cost would be offset if just one employe were absent for three weeks once in three years.

As another possible approach, disability insurance premiums might be lumped into the medical/dental expense plan. Thus, a single plan covering all employes (physicians and staff) for up to 5 percent of each person's salary could provide for all three of the discussed fringes: medical (health) insurance, disability insurance, and uninsured medical and dental expenses. For the $60,000 a year doctor, $3,000 of such allowance may meet all his needs, while the cost of covering an $8,000 a year secretary will not be too costly. The physician may thus not have to provide disability insurance for his staff since they may instead use their 5 percent allowances otherwise.

While not the primary incorporation item, health-oriented fringe benefits offer real tax-saving opportunities. Misuse can result in costly income taxes, so careful advice and planning is important.

Even more importantly, proper health benefit programs are essential to a physician and his family. Failure to have the right insurance coverage can result in real financial catastrophe. The physician should realistically evaluate his own personal arrangements in light of his relationship with a professional corporation. □

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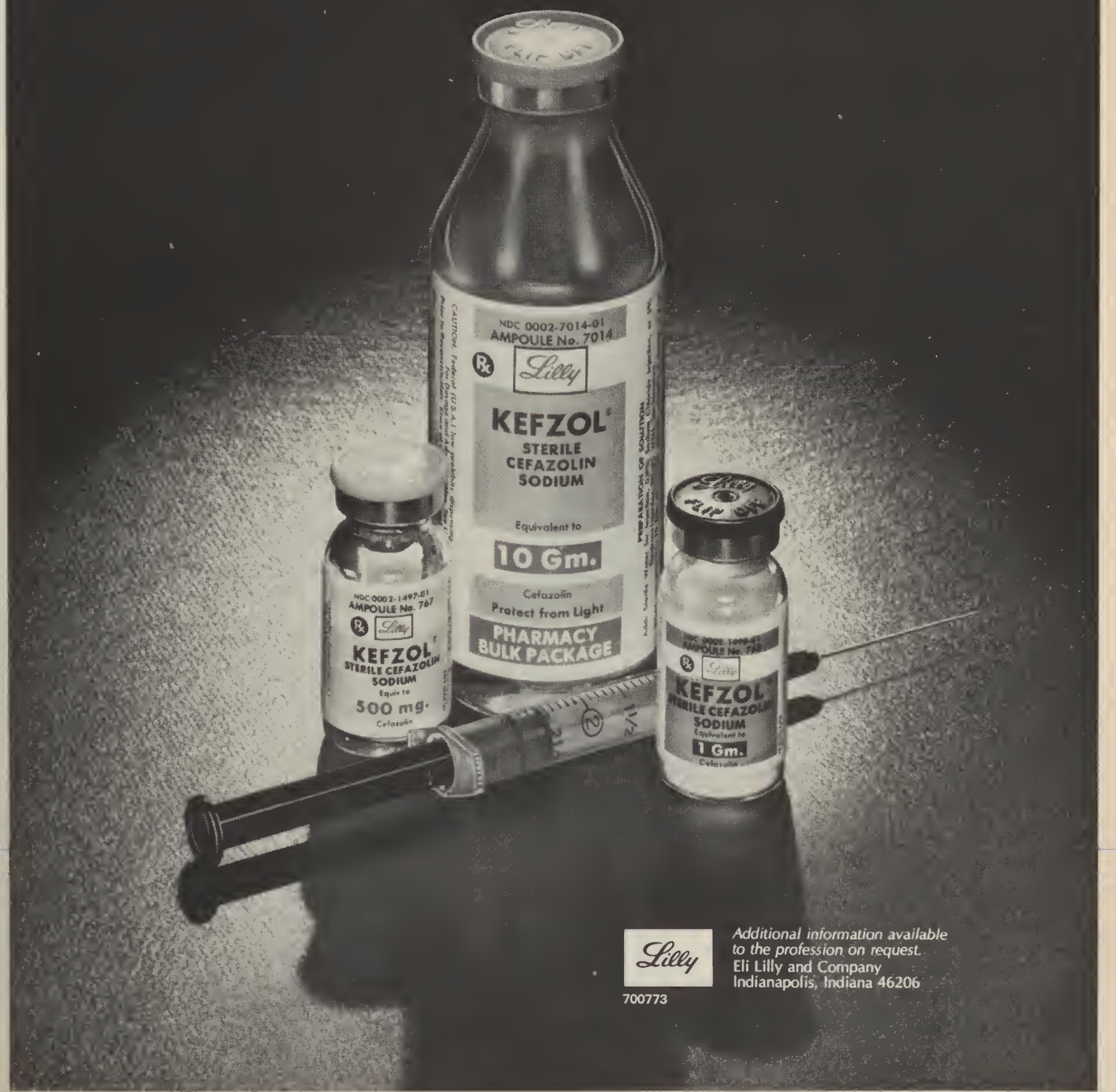
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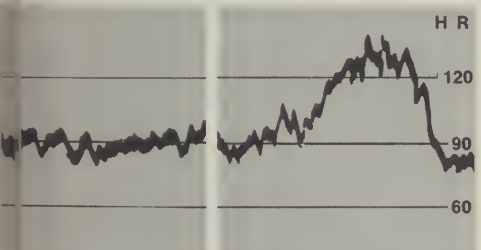
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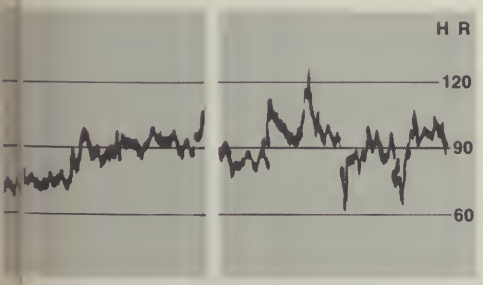
The energy cost of sex to the heart is relatively modest.
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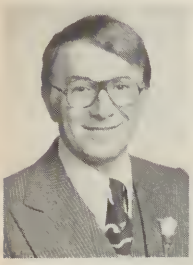
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MDs in the news

Mark S. Reed, M.D., Shillington, director of the department of pathology at Reading Hospital and Medical Center, was recently elected the 99th president of the Berks County Medical Society. Also elected were: **Arnold V. Davis, M.D.,** Wyomissing, president elect, and **James F. Welsh, M.D.,** Mohnton, chairman of the executive council.

Matthew T. Moore, M.D., F.A.C.P., emeritus professor of neuropathology at the University of Pennsylvania School of Medicine, recently had published the Archives of the International Congresses and Society of Neuropathology. The work, published by Lea and Febiger, Philadelphia, is a historical account of the origin, organization, and development of the society from 1952 to 1977.

Victor F. Greco, M.D., Drums, has been appointed to the Advisory Committee to the Director of the National Institutes of Health. Dr. Greco is a member of the Governor's Advisory Committee for Anthracosilicosis and Lung Related Problems and is chairman of the cancer commission and principal investigator of cancer detection for the Luzerne County Medical Society.



Dr. Greco



Dr. Frankl

William S. Frankl, M.D., Penn Valley, professor of medicine and director of the cardiovascular division of the Medical College of Pennsylvania, has been awarded a Senior International Fellowship from the Fogarty International Center of the National Institutes of Health. Dr. Frankl began his year-long study in January at the Cardiothoracic Institute of the University of London.

Stephen Barrett, M.D., a practicing psychiatrist in Allentown, has devoted a lot of time to investigating and opposing quackery. In an interview in the November 1977 issue of FDA Consumer, *he discusses the seriousness of common health frauds and recommends some general guidelines for spotting quacks. Dr. Barrett has been chairman of the Lehigh Valley Committee Against Health Fraud, Inc. since 1970 and is co-editor of* The Health Robbers—How to Protect Your Money and Your Life, *a book on quackery written by physicians nutritionists, journalists, and health educators.*

At a recent meeting of the board of directors of the American Heart Association, Mideastern Pennsylvania Chapter, five new board members were elected. They are: **Gene H. Ginsberg, M.D., Charles A. Gordon, M.D., Stephen R. Shore, M.D.,** and **Geoffrey Toonder, M.D.,** all of Allentown, and **Edwin A. Sweeney, M.D.,** of Lansford.

Stewart Wolf, M.D., vice president of medical affairs at St. Luke's Hospital, Bethlehem, has been awarded an International Achievement Citation by the American Heart Association for his "unique contribution to international cardiology." Wolf was cited for the outstanding service he has rendered throughout the world in upgrading cardiovascular disease programs.

Frank Theuerkauf, M.D., Erie, was elected recently to the board of the American Board of Colon and Rectal Surgery. Dr. Theuerkauf is director of the residency program in colon and rectal surgery at Saint Vincent Health Center and is a staff member of the division of proctology at Hamot Medical Center.

Susan K. McLeer, M.D., Germantown, has been appointed director of the division of women in medicine at the Medical College of Pennsylvania. Dr. McLeer's new duties in the office of medical education will be performed in conjunction with her role as assistant dean for undergraduate medical education.

Joseph C. Maroon, M.D., associate professor at the University of Pittsburgh School of Medicine and chief of neurological surgery at Presbyterian-University Hospital, was elected recently to the executive committee of the Congress of Neurological Surgeons. In addition, Dr. Maroon will serve as the annual meeting chairman for the 1979 meeting of the congress.

M. H. Samitz, M.D., acting chief of the department of dermatology at The Graduate Hospital, Philadelphia, recently received the prestigious Clark W. Finnerud Award presented annually by the Dermatology Foundation in recognition of outstanding service as a teacher and clinician. Dr. Samitz is emeritus professor of dermatology at the University of Pennsylvania School of Medicine and the Pennsylvania College of Podiatric Medicine and served as chief of dermatology at The Graduate Hospital for 13 years.

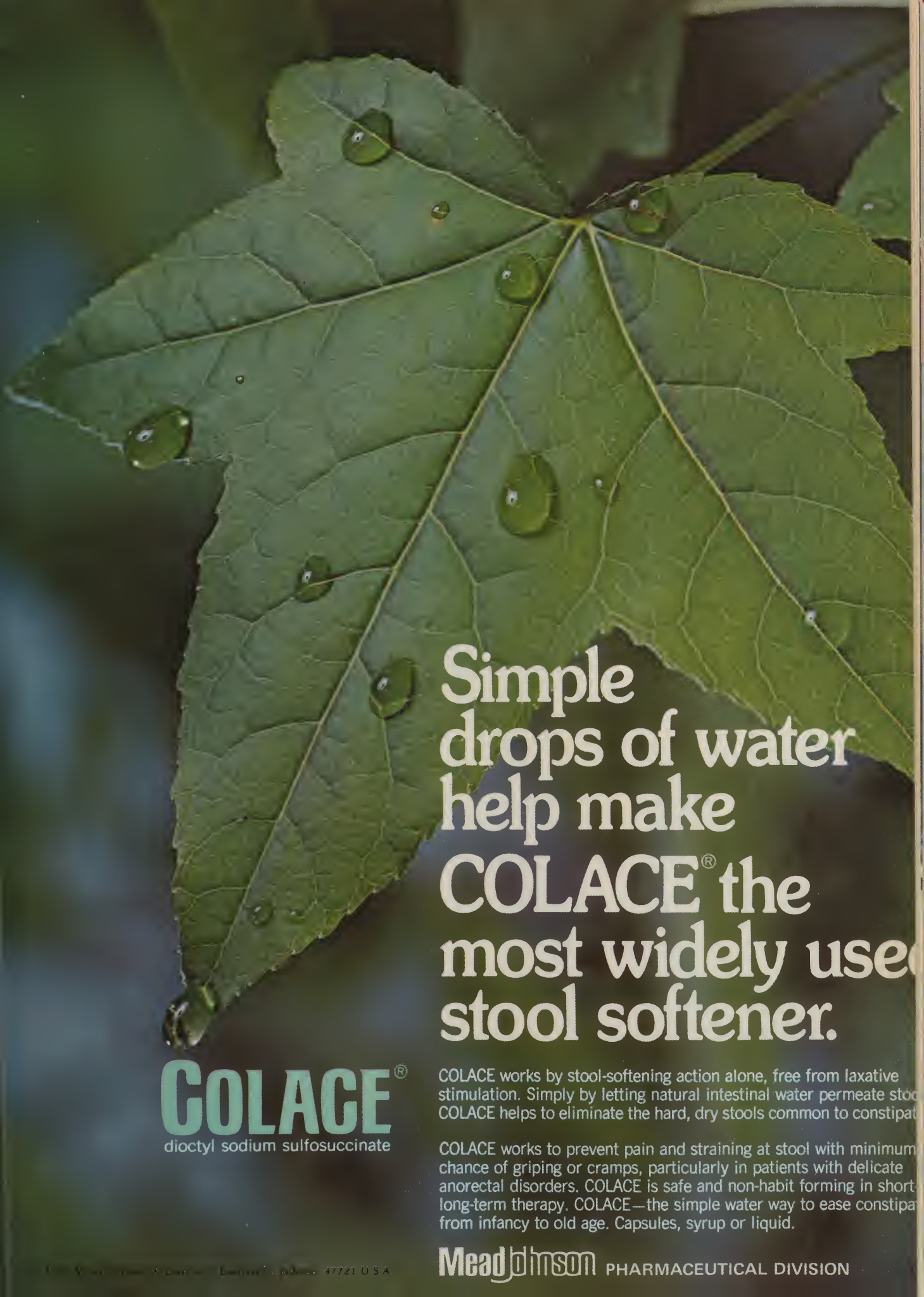


Dr. Samitz



Dr. Sholevar

Bahman Sholevar, M.D., Ph.D., Wynnewood, psychiatric resident at the Medical College of Pennsylvania, was one of a group of distinguished American and Iranian poets and novelists who recently participated in a poetry reading in New York City to benefit Iranian writers in their struggle against censorship in Iran. Before emigrating to the United States, Dr. Sholevar was a prominent Iranian novelist, poet, literary translator, and critic. At the benefit he read from his recent volume of poems, *Singing America Again.*


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Precautions: Do not administer more frequently than every 6 hours, or within 12 hours after rectal dose of any preparation containing theophylline or aminophylline. Do not give other xanthine derivatives concurrently. Use in case of pregnancy only when clearly needed.

Adverse Reactions: Theophylline may exert some stimulating effect on the central nervous system. Its administration may cause local irritation of the gastric mucosa, with possible gastric discomfort, nausea and vomiting. The frequency of adverse reactions is related to the serum theophylline level and are not usually a problem at serum theophylline levels below 20μg/ml.

How Supplied: Capsules in bottles of 100 and 1000 and unit-dose packs of 100; Elixir in bottles of 1 pint and 1 gallon.

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Office counseling

Management of psychiatric emergencies

Tjiauw-Ling Tan, M.D.
Joseph Adlestein, M.D.

A psychiatric emergency can be defined as any condition that demands prompt psychiatric attention. In most instances, however, a psychiatrist is not available and the primary physician is called upon to intervene.

Because of the nature of psychiatric emergencies, the diagnosis usually is not clear and the physician must focus on the patient's primary complaints and the immediate alleviation of symptoms. For these reasons, it is easiest to deal with emergency psychiatric problems by grouping them into primary symptom categories instead of diagnostic classifications.

In this article, we will first describe the basic principles of crisis intervention and then discuss the management of specific problems as defined by their primary symptoms.

Crisis intervention

The relief of acute symptoms in psychiatric emergencies or crises can be achieved through careful observation, verbal communication, a thorough physical examination, pharmacologic treatment, and/or environmental manipulation.

Listen and observe—During the intervention process, the physician has to use his common sense and his intuitive resources. He should be aware of his own emotional responses, be capable of tolerating anxiety-provoking situations, and be able to contend tactfully with fear and anger.

The interview should be conducted in a calm and considerate manner. A relaxed, interested inquiry about the patient's difficulties encourages him to yield information about himself. In many cases, psychiatric emergencies can be managed by helping the patient to understand the crisis intellectually, to express his feelings properly, to identify his coping mechanisms and support systems, and to reopen his social world.

Information from others—A clinical assessment is complete only when relevant information is obtained from sources other than the patient, including relatives, friends, neighbors, and bystanders. Although gathering this information may be time consuming, the efforts are necessary to avoid errors of management and indecisive treatment.

Physical examination—To determine whether the manifest psychopathology is caused by medical, psychological or pharmacological factors, the total evaluation for a psychiatric emergency should include a thorough assessment of the patient's general medical status. In addition, certain laboratory studies may be indicated.

Medication—The indications for the use of psychotropic medication depend on the severity of the symptoms. In psychiatric emergencies, such medication is used judiciously and is most often utilized for the target symptoms of agitation, excitement, anxiety, ideas of persecution, and hostility.

Community resources—Many resources are available within the community to assist the physician with the resolution of psychiatric emergencies (Table 1). The primary resource for supportive help is the local county mental health and mental retardation (MH/MR) program.

Psychiatric referral—In managing a psychiatric emergency, it is often difficult to decide whether the patient should be hospitalized or allowed to return home with the option of follow-up care. When there have been longstanding emotional conflicts prior to the emergency, more intensive psychiatric treatment is usually indicated.

The suicidal patient

Suicide ranks among the first ten causes of adult death in this country. Suicide attempts and threats are even more frequent. The typical suicide attempt is made by a white female, twenty to forty years old, who ingests pills, usually after an interpersonal conflict. The "successful" suicide is typically forty-five years of age or older, male, white, living alone, probably unemployed or retired, and often separated, widowed, or divorced. Historical factors of poor physical health, medical care within the previous six months, evidence of psychiatric disturbance (including alcoholism

Dr. Tan is director of the inpatient psychiatry unit and of emergency psychiatry services of the department of psychiatry at The Pennsylvania State University College of Medicine, Hershey. Dr. Adlestein is chief of psychiatry and director of emergency psychiatry services at Harrisburg Hospital Mental Health/Mental Retardation Center.

Primary physicians often must intervene in psychiatric emergencies when a psychiatrist is not available. The authors examine the basic principles of crisis intervention and discuss management of primary symptoms.

and drug abuse), and previous suicide attempts or threats are common in those who have committed suicide.

Clues to suicidal intent—The patient may verbalize his intentions indirectly by making tangential reference to dying ("Things would be better off without me"), or by making direct threats ("I'm going to end it all"). Life-threatening behavior may be expressed indirectly through actions which imply that death is expected, for example, making a will or giving away prized possessions.

Among the situations creating a sense of despair, despondency, and isolation are the diagnosis of a terminal illness, body-disfiguring surgery, and death of a close relative or friend. Certain symptoms or syndromes carry a higher risk of suicide: these include depression, disorientation, and schizophrenia with auditory hallucinations commanding a person to kill himself.

The method of suicide that the patient has chosen is another extremely important index of the seriousness of his intent. Three factors are significant:

- Availability—The likelihood of suicide increases with the availability of an instrument of death. The threat is greater, for example, if the individual is a sportsman who owns guns rather than someone who does not have access to one.
- Specificity—A threat of, "I'm going to shoot myself in the bedroom right after work tomorrow," is far more serious than, "I'm thinking about killing myself."
- Lethality—Lethality refers both to the rapidity of the method's effect and its nonreversibility. A loaded gun in the hand of a depressed person is far more serious than a handful of aspirin.

The management of a patient with suicidal intent involves precautions against self-harm and often requires hospitalization. When a definite risk is suspected, every precaution must be taken to prevent the patient from harming himself. Until final disposition is made, the patient should be observed on a one-to-one basis and should not be left alone under any circumstances. In arranging disposition, the physician has legal powers which must be used when necessary. Involuntary commitment can be arranged through the local MH/MR administration (Table 1).

The assaultive patient

Contrary to popular belief, psychiatric patients seldom behave aggressively. Actual risk of physical harm to the physician is usually exaggerated. There are, however, some mental conditions and disorders that increase the risk of assaultive behavior: these include certain types of schizophrenia, especially paranoid schizophrenia; psychomotor epilepsy; antisocial and explosive personality disorders; and conditions induced by alcohol or other drugs.

The self-referred patient who expresses fear of losing self-control should be taken seriously because he perceives himself to be a threat to others. Noteworthy characteristics of the potentially assaultive patient are acute anxiety and panic, fear of losing control, ambivalent feelings toward those in the environment, and undisguised, straightforward hatred and anger. The more intense these symptoms, the more probable is the occurrence of violent behavior.

The management of patients with a high risk of assaultive behavior demands patience, willingness to understand and to provide clarification and assurance, and the ability to aid the patient in marshalling his own resources for self-control.

In cases in which immediate and effective sedation is required, haloperidol can be given intramuscularly in a dose of 3-5 mg according to the patient's weight and physical condition. If the response is inadequate, a similar or smaller dose may be given in about one hour. Previously, chlorpromazine was commonly used with such patients, but this drug has a hypotensive side effect which is not characteristic of haloperidol.

Decisive and effective physical control over the disturbed patient is usually needed. Adequate assistance and resources should be assembled before any necessary force is employed since a patient confronted with ambiguous and hesitant restraint can become more fearful and hostile, and therefore more dangerous.

Whenever homicidal risk is evident, hospitalization becomes mandatory.

The confused patient

Confusion and mental disorganization may represent an acute episode of psychosis on an organic or a functional basis.

Organic brain syndrome—Acute organic brain syndrome is the result of

an alteration in cerebral metabolism caused by toxic, metabolic, traumatic, vascular, neoplastic, or degenerative processes. The basic symptoms are the result of impairment of all intellectual functions, such as comprehension, calculation, knowledge, and learning. Hallucinations and delusions may be present.

The confusion and disorganization will improve as the underlying etiologic process is treated. If the patient remains somewhat alert, reassure him and explain what is happening to him in a simple way. A calendar and family pictures in the room help to orient the patient by day and a night light usually prevents the confusion and disorientation that may result from the room being too dark. When a patient becomes unmanageable, a low dose of antipsychotic medication, such as 0.5 to 1 mg of haloperidol, may be helpful. Central nervous system depressants, such as barbiturates, are contraindicated because they may add to the patient's confusion.

Drug psychosis—The clinical picture of drug psychosis reflects an interaction of the premorbid personality

Table 1. Community Resources for Psychiatric Emergencies

Problem	*Community Resource*	*Sponsor*
Life-threatening behavior	Crisis intervention[1]	County MH/MR[2]
Violent and/or irrational behavior	Crisis intervention	County MH/MR
Acute family crisis	Crisis intervention	County MH/MR
Involuntary hospitalization	Crisis intervention	County MH/MR
Drug abuse	Addictive disorder clinic—outpatient	Local drug & alcohol program (may be part of MH/MR or independent)
	Methadone maintenance—outpatient	Local drug & alcohol program
	Special drug treatment program at local base service unit—outpatient[3]	Local drug & alcohol program
	Residential treatment facility	Local drug & alcohol program
Alcohol abuse	Alcohol treatment center—outpatient	Local drug & alcohol program
	Special alcohol program at base service unit—outpatient	Local drug & alcohol program
	Detoxification center	Local drug & alcohol program
	Rehabilitative residential treatment	Local drug & alcohol program
	Alcoholics Anonymous (including Alanon and Alateen help for spouse and family)	Independent
Rape	Rape crisis center (if not available, refer to base service unit)	Usually independent group of concerned citizens
Other emergency problems	All county MH/MR Units are required to provide a central information and referral service	

[1] If your community does not provide crisis intervention service, the 24-hour emergency service of the county MH/MR can be used.

[2] County mental health and mental retardation service.

[3] The base service unit is the chief administrative and treatment area of the MH/MR service.

and physical health of the user, the characteristics of the environment, the number and types of drugs used (e.g., heroin, methadone), the dose of drug, and the method of administration.

The symptoms of amphetamine or cocaine psychosis are similar and are virtually indistinguishable from paranoid schizophrenia, which is characterized by paranoid ideation with delusions of persecution associated with a clear sensorium. When these drugs are withdrawn, the symptoms generally pass. Haloperidol can be prescribed to treat the excitement that occurs with acute intoxication.

Hallucinogenic psychosis can occur within one hour of ingestion of one or more hallucinogens (e.g., LSD, mescaline, DMT, psilocybin, STP, etc.), but it usually resolves without treatment in 4 to 16 hours. If there is a strong anxiety or panic component, 15-30 mg of diazepam should be given orally or intramuscularly. Medication should be repeated in the same dosage range if the patient does not respond within an hour. If there is no significant response within six hours, hospitalization may be necessary.

Alcohol intoxication—A patient who behaves abnormally and also smells of alcohol does not necessarily have a primary problem of alcohol intoxication. It is possible that other psychiatric or medical conditions also are present. For example, schizophrenics occasionally drink excessively to relieve their symptoms, and depressed patients often drink heavily.

Because the patient with acute alcohol intoxication is already confused due to an impairment of higher cortical control, he should be allowed to metabolize the alcohol without being given additional medication. The physician should try to avoid arguments, and the patient should be settled comfortably in a quiet, darkened room with a minimum of disturbance. If this approach fails, control is best achieved by oral or intramuscular administration of 50-100 mg of chlordiazepoxide or 10-20 mg of diazepam. In all cases, the lower doses of these drugs should be tried first because the drugs may potentiate the effects of the alcohol.

Functional psychoses—Functional psychoses associated with schizophrenia are characterized by primary symptoms of conceptual disorganization which may lead to misinterpretation of reality and sometimes to delusions and hallucinations. Functional psychosis may also be related to a major affective disorder, such as mania or depression. In these cases, the psychosis is characterized by extreme depression or elation that dominates the life of the patient and may result in a loss of contact with the environment.

Schizophrenia—In acute schizophrenic episodes, the symptoms most often noted are bizarre and idiosyncratic speech, delusions, hallucinations, and inappropriate affect; there is no disturbance of orientation or memory. The management of this condition includes referral for hospitalization and antipsychotic medication. If the patient is cooperative during the interview, sedation may not be necessary. If the patient is initially agitated or becomes so agitated that he cannot be interviewed, medications such as haloperidol (5 mg) or chlorpromazine (50-100 mg) may be given parenterally.

Affective disorder—The most common symptoms associated with affective disturbance are depression, psychomotor retardation, manic or hypomanic excitement, guilt, hopelessness, and self-deprecation. When these symptoms are severe, medication for agitation, such as haloperidol or chlorpromazine, may be necessary. Referral for hospitalization and pharmacologic intervention with antidepressant medication or lithium should be considered.

The rape victim

Psychological management of the rape victim follows the general principles of crisis intervention. This includes allowing the patient to ventilate her feelings adequately, empathetically focusing on her present problems, and encouraging her return to normal functioning as soon as possible. On occasion, when there appears to be a more fundamental psychiatric problem that may have predisposed the patient to assume the risks that led to the rape, such as schizophrenia or alcoholism, she should be referred for follow-up psychiatric care.

In many cases, psychiatric emergencies can be managed by helping the patient to understand the crisis intellectually, to express his feelings properly, to identify his coping mechanisms and support systems, and to reopen his social world.

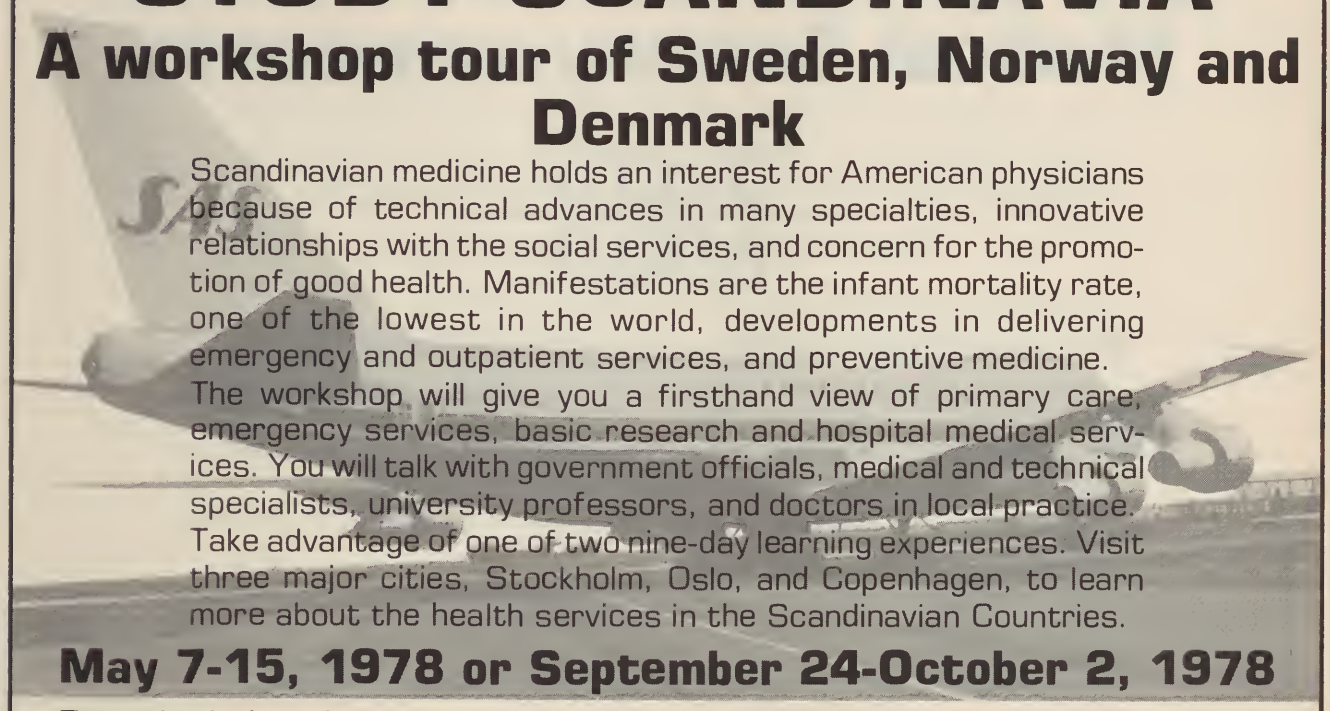
The medical management of the rape victim should include:

- Obtaining a specimen from the vaginal fornices for the police laboratory to inspect for acid phosphatase and blood antigen of the semen. Both cervical and rectal cultures should be taken for gonorrhea and a serology should be obtained for syphilis.
- Prescribing antibiotics for the prevention of venereal disease. A serology for syphilis and a test for gonorrhea should be obtained again after six weeks.
- Offering methods to prevent pregnancy. Oral administration of methoxyprogesterone or diethylstilbestrol for five days has been recommended. If menstruation does not occur within one week after cessation of the estrogen, all alternatives, including abortion, should be made available to the patient.

Physicians may be called upon to testify in court for the rape victim. It should be understood that the decision of whether rape has occurred is not a medical diagnosis but a legal determination. The examining physician's primary legal responsibility is to accurately document his findings. □

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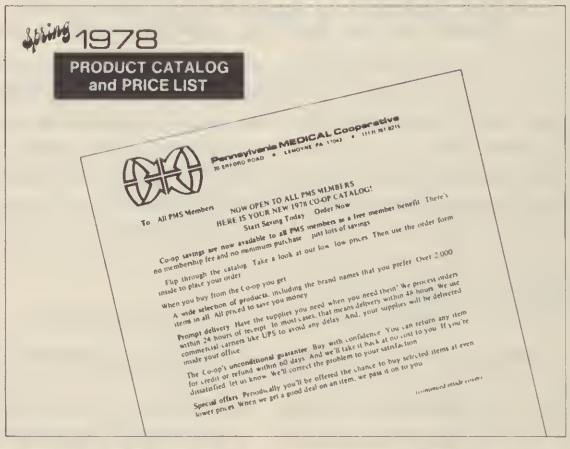
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editorials

Life styles and health costs

Have you ever had to tell a patient that you could prescribe to relieve the symptoms but could not cure the underlying disease? The situation is frustrating to the physician and incomprehensible to the patient. Yet this is the problem confronting physicians, the public, and the health care financing system in this country.

In 1974 the leading causes of death in the United States, according to *Vital Statistics*, were: (1) heart disease (38.2%), (2) cancer (18.6%), (3) stroke (10.7%), (4) accidents (5.4%), . . . (7) cirrhosis (1.7%), (8) arteriosclerosis (1.7%) . . . (12) emphysema (1.0%). Many of these deaths could have been prevented if the disease had been delayed in onset with alteration of life styles, i.e., proper diet, exercise, abstention from cigarettes and alcohol, and use of seat belts and shoulder harnesses.

William B. Kannel, M.D., of Framingham study fame, has said that tobacco is estimated to cause approximately 325,000 premature deaths per year. Alcohol use and abuse is directly related to the development of cirrhosis, and indirectly to automobile accidents and obesity. The American problem of overweight is a significant contributor to diabetes mellitus, heart disease, and stroke. There has been an apparent decline in the number of auto accident-related deaths since 1973, when the speed limits on the nation's highways were reduced. There would be another reduction if more drivers could be induced to use seat belts and shoulder harnesses.

The cost of medical care in the United States has continued to climb over the last 25 years and no end is in sight. In 1950 total health care expenditures were $12 billion, or 4.6 percent of the gross national product; in 1965, $38.9 billion, or 5.9 percent of the GNP; in 1975, $118.5 billion, or 8.3 percent of the GNP. Despite these increases, no miraculous breakthroughs have occurred. During this same period government expenditures for health have increased from $3.1 billion to $49.9 billion.

Although the government continues to allocate more money for health, these massive spending programs and attendant government regulations have failed to significantly improve our national health.

Is the government treating symptoms instead of disease like the hypothetical physician above? The answer, unfortunately, is yes. Agricultural subsidies to the tobacco industry contribute to the production and manufacture of cigarettes. Like the dog chasing its tail, this policy is counterproductive to efforts to decrease the major killer diseases. The fire is being fueled while desperate, expensive efforts are being made to quell the flames.

Although accidents are the fourth leading cause of death in the United States, precious little has been done to control the drinking driver or to impose penalties for failure to wear seat belts. Americans are sadly ignorant of what constitutes a proper diet and are largely guided by the advertising industry. With little proof of improvement in national health, "health foods" are a successful fad.

Cut costs? PSRO, HSA, the plan for a 9 percent cap on hospital revenue increases, and all the other government regulations have limited chances of success and may damage the present system beyond recognition without preventing anything. Why? Primarily because the source of the diseases is allowed to continue unchecked. A reemphasis of an old approach is needed, one that is aimed at the reduction and eradication of the *causes* of disease. The price of prevention is far cheaper in the long run than the futile, ineffective way we are now dealing with the problem.

We must become involved in more and expanded programs to educate the American public that our life styles are the cause of many serious diseases. Prevention must be paid more than lip service. Prevention means more than immunization against infectious diseases. It provides us with the most effective method to control the growing demands on our health care resources.

David A. Smith, M.D.
Medical Editor

correspondence

'Other side' on request

To the editor:

As I understand it, editorship involves the airing of two sides of a question.

I appeal to you to publish this letter in PENNSYLVANIA MEDICINE if you subscribe to this principle.

Elizabeth Hooton McNeal M.D.

Dr. William J. Kelly, President
Pennsylvania Medical Society

Just a few years ago I carried my medical malprac-

tice insurance with a local insurance agent whom I respect, with a company which enjoys a good reputation.

A full page ad in PENNSYLVANIA MEDICINE (December 1973) urged me to join Argonaut policyholders.

I changed my insurance policy to Argonaut. Within a year or two the rumblings began, indicating that all was not well with Argonaut.

Then came word that after January 1, 1978, no Argonaut insurance would be issued.

I telephoned my local insurance representative, reminded him that I had dropped my insurance with him, and asked if medical malpractice insurance were obtainable again with my old company. After investigating, his answer was that it could be obtained through JUA only.

Subsequent to this, I received a letter dated October 3, 1977, stating that there is a mandatory assessment for the set-up of an insurance company by my Pennsylvania Medical Society, which had previously urged me to "go Argonaut." Not only that, but I am threatened by ineligibility in my county, state, and AMA medical societies, should I not pay my mandatory assessment.

I do not believe that the answer to any problems is the establishment by a medical group of an industry competitive with private industry. An outstanding example is the establishment of the Pennsylvania Medical Society-backed Cooperative for selling supplies to the profession at lower prices. My colleagues and I have found that, instead of being competitive, items can be obtained more inexpensively on the open market.

I have no intention of paying this "mandatory" assessment to establish a Pennsylvania Medical Society insurance company. If suspension from county, state, and national medical societies is the result, so be it.

The pity is that this unjust measure is taken at the expense of my rights, by my own colleagues.

Elizabeth Hooton McNeal, M.D.
Easton

Editor's Note: Additional facts are needed to understand this case. The doctor's original insurance policy was with Aetna. Aetna withdrew from the medical malpractice insurance market in Pennsylvania, leaving some 1,200 physicians without coverage at the height of the crisis. Thanks to the efforts of the Pennsylvania Medical Society, there was a place to turn for those physicians deserted by Aetna.

The Society had a contract with Argonaut providing guaranteed coverage to members through May 31, 1979. PMS has forced Argonaut to abide by this agreement through court action while seeking a permanent alternative.

If the Society had not been vigilant in this regard, all physicians in the state by now would have been forced to turn to the Joint Underwriting Association. Why? Because the Insurance Commissioner would have been forced to declare the Joint Underwriting Association the exclusive source for medical malpractice insurance when those physicians in Classes III, IV, and V covered by Argonaut sought in vain for coverage elsewhere. This would have meant that the thousands of physicians with Medical Protective coverage would be forced into the JUA also. While Medical Protective writes new policies for a few physicians in all risk classes, it does so only as its current number of insureds drops in the individual risk class because of retirement or death.

If there existed a competitive open market for medical malpractice insurance in Pennsylvania, the Society's company would not have been needed, and would not be formed.

Rather than being "competitive with private industry," as Dr. McNeal says, the forming of PMSLIC is making it possible for the private malpractice insurance industry to operate in Pennsylvania.

D. A. S.

September issue mail continues

To the Editor:

The article, "Home Health Care—Another Way to Reduce Costs," (September 1977) was very timely. As the author points out, "Home health care's use has been limited, possibly due to physicians' lack of awareness or understanding of the services." A follow-up article on the specific activities of Area Agencies on Aging might be in order.

For example, the Philadelphia Corporation for Aging, which is the Area Agency on Aging for Philadelphia, provides in-home services through an organizational structure which utilizes a blend of technical expertise and efficient management techniques. In this way, it is assured that the maximum amount of dollars go into direct services, rather than being dissipated. The PCA model also separates the functions of service delivery from those of evaluation of service quality.

At present, PCA's In-Home Service Department is involved with 800 to 900 clients for homemaker services; 350 clients receiving meals; and 225 clients who have received chore services.

The Philadelphia Corporation for Aging is demonstrating daily that it is possible to give significant help to the elderly by mixing management with social consciousness.

Rodney D. Williams, Executive Director
Philadelphia Corporation for Aging

in my opinion

Standardized informed consent—clearing 'muddied water'

At the March 1977 AMA—ABA meeting in San Francisco, Judge C. Kimball Rose of Phoenix, Arizona suggested that informed consent be standardized.

The Mercer County Medical Society introduced a resolution on standardized informed consent at the House of Delegates meeting of the Pennsylvania Medical Society in October. There was no opposition to this resolution and it was referred to the Interspecialty Committee for further study and possible implementation.

One of the main reasons that informed consent is such a problem today is that physicians are using different consent forms. For example, let us assume there are 200 radiologists doing angiography in Pennsylvania. They are probably using 180 different consent forms. Some of these forms are very short and general and some are very long and complex. This is what the trial lawyers love. "Doctor, why didn't you warn your patient of the possibility of a pulmonary embolus?" "Are you aware, Doctor, that Dr. Jones who practices radiology just 10 miles away warns all his angiography patients of the possibility of a pulmonary embolus?"

It seems logical that all physicians doing the same medical or surgical procedure should be using the same consent form, one devised by physicians who are doing that particular procedure. We think the Pennsylvania Radiological Society should appoint five angiographers to devise a consent form agreed upon by all. It should be as short and simple as possible and still conform to the reasonable man concept. Then when a physician is asked in the court room why he didn't warn his patient of the possibility of a pulmonary embolus he can say, "I am a member of the Pennsylvania Radiological Society. That organization appointed five distinguished angiographers to review the problem of informed consent for angiography. After much study they devised a form that is reasonable and best for the patient from a medical point of view. This form has been recommended by the Pennsylvania Radiological Society to all of its members and this is the form that I have used."

Three points of the informed consent law are: (1) you must warn your patient of all risks that a reasonable man would want to know; (2) in each malpractice case the jury must decide what a reasonable man would want to know; and (3) to assist the jury in deciding what a reasonable man would want to know, expert testimony can be given as to the standard of medical practice.

If 80 percent of the angiographers are using the same consent form, this would be the standard of medical practice.

We have two main objectives in introducing this resolution: (1) if all doctors are using the same consent form and if that form is the standard of medical practice, then informed consent is less likely to be an issue in malpractice cases; and (2) everyone will know that physicians and physicians alone will set their own standards of medical practice. We must insist that what a physician tells a patient prior to a medical or surgical procedure is part of the practice of medicine and therefore only physicians are qualified to set standards of informed consent. Informed consent today is in a state of chaos because it is a medical problem that we have attempted to solve with legal opinions. As long as physicians think they have to ask attorneys what to tell patients before a medical or surgical procedure, informed consent will remain in a state of chaos.

The Pennsylvania Radiological Society has already taken several steps in standardizing informed consent. At the May 1977 meeting a resolution was passed unanimously that radiologists should not obtain informed consent for IVPs. Since anxiety and apprehension increase the incidence of IVP reactions, it was decided that from a medical point of view it was best not to obtain informed consent for excretory urography. The obligation of any physician is to do what is medically correct for his patient rather than what he thinks may be legally best for himself. At the meeting of the Board of Directors of the Pennsylvania Radiological Society in October a resolution was passed that five angiographers would be appointed to study the possibility of devising a standard angiography consent form.

Physicians may decide to use a written consent form, oral informed consent with a note on the chart or, as in the case of the IVPs, no informed consent at all.

There is not much that we can do as physicians to ease the malpractice crisis or to lessen the involvement of our legal brethren in the practice of medicine. We think that standardizing informed consent will help just a little in both of these areas.

Robert W. Allen, M.D.
Sharon

Dr. Allen is secretary of the Mercer County Medical Society and a leading proponent of the resolution to standardize informed consent.

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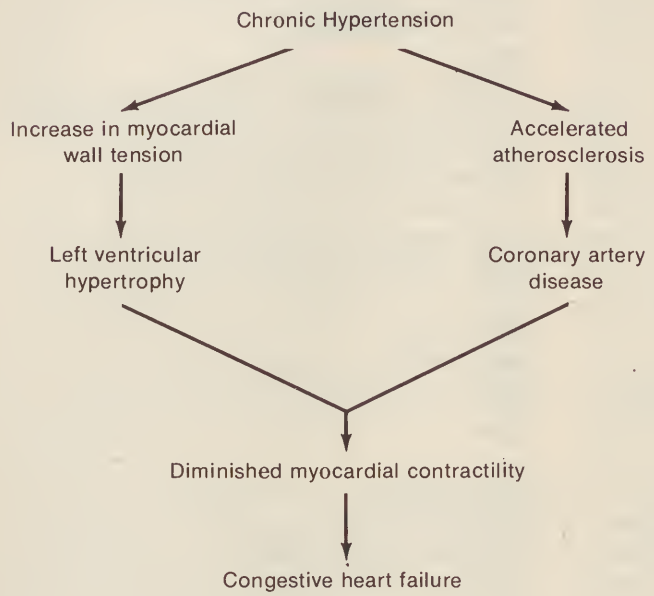
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Functional and pharmacological considerations

Relationship of hypertension to heart failure

Michael J. Reichgott, M.D., Ph.D.
C. Venkata S. Ram, M.D.

Figure 1. Effects of Hypertension on Cardiac Performance



Hypertension and congestive heart failure (CHF) are common cardiovascular diseases that are closely interrelated and that may occur simultaneously in the patient. Effective therapy exists for each of these diseases. But when they are coincident, modifications of treatment strategy may be necessary in order that therapeutic interventions appropriate for one condition do not adversely influence the other.

Much is known about the pathophysiologic mechanisms of both hypertension and CHF. Similarly, the pharmacologic actions of available drugs are also well understood. Therapeutic interventions can be tailored, using this knowledge, to deal directly with presumed pathophysiology, and the risk of untoward drug reactions can thereby be reduced. In this communication we review the interactions between hypertension and CHF and outline the considerations which could influence choice of therapy.

Pathophysiologic interactions

Hypertension is present in a large proportion (as high as 20 percent) of the adult American population.[1] Drug therapy has been demonstrated to effectively reduce the morbidity in this condition.[2] Nonetheless, CHF is a common complication of long-standing hypertension; in the Framingham study, hypertension has been shown to precede heart failure in 75 percent of patients between the ages of 35 and 62 who developed this problem.[3]

The authors are associated with the hypertension and clinical pharmacology section of the Hospital of the University of Pennsylvania, Philadelphia.

Figure 1 illustrates the effects of hypertension on cardiac performance.

The myocardium can compensate, by hypertrophy, for prolonged pressure loading.[4] However, even the hypertrophied ventricle will fail if not relieved of prolonged hypertension. In addition, hypertension may be a significant risk factor in the development of coronary vascular arteriosclerotic disease. This can limit delivery of oxygen and energy substrates necessary for myocardial function, and can contribute to the development of heart failure.

The role of hypertension in the pathogenesis of CHF is well understood. Less generally appreciated, however, is the fact that hypertension can be a consequence of myocardial failure. This occurs as a result of the compensatory mechanisms which support the myocardial contractility in the event of cardiac decompensation.

When myocardial contractility begins to diminish, long before symptomatic CHF is evident, compensatory mechanisms which act to maintain adequate cardiac output respond. These compensatory mechanisms can cause elevation of the blood pressure. Elevation of the blood pressure, by increasing myocardial work, could oppose such compensatory mechanisms. Ultimately, despite intrinsic compensation, symptomatic congestive failure may supervene. Because the mechanisms for compensation may cause elevation of blood pressure before other symptoms of failure are evident, changes in the status of blood pressure control should be viewed as a possible manifestation of "occult" congestive heart failure in patients at risk.

Two compensatory mechanisms

exist. The first, sympathetic nervous system reflexes, are rapidly responsive.[5] The stimulus for this reflex is decreased effective cardiac output. This is detected by the carotid and aortic baroreceptors and increased sympathetic nervous out-flow results. A multi-fold response, including venoconstriction, arteriolar constriction, and increased cardiac rate and contractility, results.

Venoconstriction results in increased venous return to the heart (pre-load) and, in conjunction with increased cardiac rate and contractility, causes increased cardiac output. Arteriolar constriction, however, serves only to raise peripheral vascular resistance. Because blood pressure is the product of cardiac output and peripheral vascular resistance, increases in both of these functions results in the elevation of the blood pressure.

The second, more slowly operating, compensatory mechanism is that of blood volume expansion. Reduction in effective cardiac output diminishes renal blood flow. As a result, sodium and water are retained. In addition, diminution of effective renal blood flow results in stimulation of renin secretion which in turn leads to hyperaldosteronism and the latter serves to perpetuate the volume retention.

Expanded blood volume increases ventricular pre-load and the Starling effect of stretching myocardial muscle fibers increases intrinsic myocardial contractility. Restoration of contractility by volume-Starling mechanisms may reduce the need for excess sympathetic tone, and blood pressure may return to normal. If progressive myocardial failure occurs, however, both neurogenic and volume compensatory mechanisms will remain active. Continuous elevation of peripheral vascular resistance will be manifested by elevations of diastolic blood pressure.

The clues to "occult" heart failure are: unexplained tachycardia, hypertension (often with further diastolic elevation upon assumption of the upright posture), weight gain, and fatigue. Only later do the more classic signs of CHF become manifest. Attempts to control only hypertension, without recognition of possible myocardial failure, may make the situation worse since several drugs that are useful for hypertension may block the cardiac compensatory mechanisms.

Pharmacologic interactions

The reduction of blood pressure is accomplished by reduction of cardiac output (either directly or by volume control), by reduction of peripheral resistance, or by combination of these factors. Obviously, when CHF is present, reduction of cardiac output or alteration of sympathetic reflexes could be detrimental. Conversely, support of myocardial contractility should exert no negative influence on blood pressure and could obviate the need for antihypertensive therapy by removing the possible cause of hypertension.

With these principles in mind, it is possible to categorize available pharmacologic agents as follows:

1. Drugs beneficial in both hypertension and congestive failure (diuretics);

2. Drugs specific for either hypertension or congestive failure and indirectly useful in management of the other process (vasodilators in hypertension, digitalis in congestive heart failure);

3. Drugs specific for hypertension which may be detrimental in congestive heart failure (propranolol, other sympatholytic agents).

Diuretics—Volume reduction, using diuretic agents, is the cornerstone of management of both hypertension and symptomatic CHF. In conjunction with specific antihypertensive agents or with digitalis, either disease can be managed. Several classes of diuretic agents are available, and their selection is usually dictated by considerations of cost, compliance, and hypersensitivity or untoward biochemical events.

Two considerations are of specific importance when using diuretics in the context of hypertension and congestive failure. First, if digitalis is to be used for treatment of failure, the kaliuretic effect of thiazide or loop diuretics must be considered. Hypokalemia increases the risk of digitalis-induced cardiac arrythmias. When hypertension is present, diuretic-induced kaliuresis may become easily manifest, due to primary or secondary hyperaldosteronism. Therefore, either potassium sparing diuretics should be selected (provided that renal function is normal) or adequate potassium replacement must be provided, if necessary, to maintain adequate serum potassium.

Second, if potent diuretic therapy is selected in the context of "occult" congestive heart failure, the results may be paradoxic. Excessive diuresis may reduce effective cardiac output by removing volume necessary to maintain the Starling effect. Sympathetic tone may then be substituted, and the rise in peripheral resistance may result in elevation of blood pressure. Associated phenomena would be significant tachycardia and prerenal azotemia. These events should alert the clinician to the concurrent phenomena of myocardial failure and hypertension.

Digitalis—This family of glycosides directly effects myocardial muscle to increase contractility. Little, if any, direct effects on blood pressure would be expected with this agent. But by removing the need for volume or sympathetic compensation for failure, digitalis therapy can indirectly influence the blood pressure.

There are no hard guidelines to indicate when digitalis is beneficial in the hypertensive patient in the absence of symptomatic heart failure. A high index of suspicion of "occult" heart failure, attention to details of history such as increasing fatigue, decreasing exercise tolerance or subtle changes in pre-existing patterns of angina pectoris, physical signs such as tachycardia, and especially increasing hypertension despite continuation of previously successful antihypertensive therapy, may dictate the need for a trial with digitalis. Maintenance digitalis may be of special value in some patients, especially when sympatholytic agents are added for control of hypertension.

Vasodilators—Vasodilators have been useful in the management of hypertension in acute and chronic situations. Hydralazine, prazosin, and minoxidil are the orally effective drugs, while nitroprusside and diazoxide and occasionally hydralazine are given parenterally.

In general, vasodilators can cause

reflex tachycardia (with the exception of nitroprusside and the new agent prazosin). In patients with CHF, tachycardia is undesirable because the ventricular filling may be reduced and because in the presence of coronary insufficiency, increased myocardial oxygen demands may not be satisified.

Nitroprusside, however, usually does not cause tachycardia and is highly effective in the management of hypertensive emergencies. Nitroprusside has been successfully used to ameliorate the symptoms of refractory congestive heart failure[6] by reducing the impedence in the resistance vessels, resulting in the improvement of left ventricular function.

Diazoxide is another parenteral drug used in hypertensive emergencies. Reflex tachycardia and angina-like syndrome[7] have been reported with the use of this drug, and we believe that diazoxide should be avoided in patients presenting with dual phenomena of CHF and severe hypertension, a situation that is best handled with nitroprusside infusion.

Hydralazine is known to cause tachycardia; hence, its use in the patient with ischemic heart disease and/or CHF has been justifiably cautious. Recent work by Franciosa et al.[8] has suggested that hydralazine may be useful in patients with chronic left ventricular failure, by mimicking the hemodynamic effect of nitroprusside in the similar situation. Although this study has demonstrated the efficacy of hydralazine in the setting of left ventricular failure *per se*, it was not tested in patients with hypertension and concomitant CHF.

It is of considerable interest to note that the new antihypertensive drug prazosin, a vasodilator, does not cause significant tachycardia. This property is attributed to phosphodiesterase inhibition by prazosin, permitting the accumulation of cyclic GMP in the heart.[9] If this drug truly does not impair the myocardial function, it may have a special utility in the management of patients with CHF and hypertension.

If oxygen supply to the myocardium is not limiting, the reflex sympathetic response to acute vasodilation would improve contractility and thereby reduce congestive failure. It is unlikely, however, that vasodilators alone could successfully control significant hypertension. Blockade of the sympathetic reflex responses with sympatholytic agents is usually required for adequate pressure control. This places the patient with occult failure at further risk.

Sympatholytic agents—Sympatholytic agents are commonly used antihypertensive drugs. In patients with diminished myocardial reserve, however, these agents should be used with great care or avoided at times. Adrenergic nervous system plays an important role in the circulatory adjustments of a failing myocardium[10] and deprivation of this role by a sympatholytic agent could be detrimental in patients with CHF.

Beta-adrenergic blocker, propranolol, is a well known negative inotropic agent which should be avoided in patients with compromised cardiac function. The other commonly used sympatholytic agent, methyldopa, has been shown to reduce cardiac output in patients with CHF.[11] Similar adverse effects on cardiac function have been documented with the use of guanethidine in CHF.[10]

Most sympatholytic agents cause sodium and volume retention of varying degree and this has to be viewed as disadvantageous in patients with CHF. For these reasons, indiscriminate administration of large doses of sympatholytic agents to patients with CHF and hypertension should be regarded as potentially harmful.

Comment

From the above discussion it is clear that congestive heart failure and hypertension are closely interrelated. When hypertension appears or becomes more difficult to control in the elderly, in patients with long-standing hypertension, or in patients with known myocardial disease, the possibility must be considered that this is a manifestation of occult congestive failure. Therapy must be selected with care lest treatment of the blood pressure *per se* make the congestive heart failure symptomatic.

Diuretic therapy may itself be sufficient in the initial management of a patient with hypertension and CHF. But simple diuretic therapy may not be adequate for the long-term control of CHF, which requires the use of digitalis and possible removal of factors perpetuating the heart failure, if such can be identified. We therefore suggest a trial of digitalis therapy in such situations before intensifying the antihypertensive therapy.

The need for digitalis in a patient with hypertension and suspected cardiac decompensation must be assessed on the basis of history and physical findings (subtle at times), and therapy must be strictly individualized. When clinical features unequivocally suggest a recent cardiac decompensation in a hypertensive patient, the trial with diuretics must be followed by use of digitalis. The introduction of digitalis in this setting is particularly advantageous because it increases the cardiac output while it lowers or leaves unchanged the peripheral resistance.[12]

Sympatholytic agents are disadvantageous in patients with CHF and hypertension and, if they are essential to control blood pressure, ancillary measures such as natriuresis and digitalization are indicated. □

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Case study

Sedimentation of leukocytes within the joint space

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Determination of the number and kind of leukocytes in synovial fluid is probably the most important part of synovial fluid analysis, allowing the differentiation of inflammatory from non-inflammatory arthritis.

Extracellular release of leukocytic lysosomal enzymes plays a major role in the pathogenesis of cartilage destruction.[1] The synovial fluid leukocyte count and proportion of neutrophilic granulocytes therefore offers an indirect measure of the rate of joint destruction. Thus, in addition to making the diagnosis of inflammatory arthritis, the leukocyte count dictates the required tempo of evaluation and therapy of joint disease.

It is essential that the clinician examine a representative sample of synovial fluid from a given joint in order to draw valid conclusions.

We have noted that joints which have been motionless for a period prior to arthrocentesis have the greater proportion of intra-articular leukocytes in the dependent regions of the intrasynovial space. These cells and other debris are not removed until near the end of an aspiration from the superior portion of the joint. This sedimentation of particulate matter can cause different leukocyte counts in specimens removed from the same joint.

The following two cases illustrate this phenomenon. A third case demonstrating loculation of synovial fluid is presented for comparison.

Case # 1

An 18-year-old man with sickle cell disease was admitted to the hospital with left shoulder pain of 3 to 4 weeks duration. This was one of a series of admissions for sickle cell crises. He previously had multiple episodes of joint pain and x-rays documented bony infarcts. The shoulder was warm, painful, and swollen. No motion was possible because of guarding. For several hours prior to arthrocentesis, the patient had been seated upright in bed without shoulder movement.

While in this position, aspiration was performed using a 19 gauge needle from an anterior approach, supero-lateral to the coracoid process. The aspiration was atraumatic and fluid easily entered the syringe.

The first 10 ml of fluid was slightly homogeneously blood tinged. As aspiration proceeded, however, the character of the fluid entering the syringe gradually changed and the last 5 ml was opaque, grayish, purulent-appearing material. This change was not associated with change in needle position or interruption of flow.

A leukocyte count of the entire specimen was greater than 100,000/mm^3 with 95 percent neutrophils. There was abundant, poorly defined cellular and particulate debris. Most of the many red blood cells present were sickled. Gram stain and culture were negative. No crystals were seen. An x-ray showed no bony abnormalities. A technesium pyrophosphate bone scan raised the question of increased uptake in the left shoulder.

The clinical impression was of sickle cell joint disease with possible bone infarction. A repeat aspiration the next morning yielded less than 1 ml of slightly bloody fluid with a leukocyte count of 2000/mm^3. The patient recovered complete function of the shoulder.

Case # 2

A 30-year-old paraplegic man with complete sensory and motor loss in the lower extremities was evaluated for inflammatory arthritis of the knee of uncertain duration. The right knee was grossly swollen and warm, but painless.

Arthrocentesis was performed after the patient had been lying motionless on his back for several hours. Without moving the knee, the intra-articular space was easily entered from a medial subpatellar approach.

The first 20 ml of fluid to appear in the syringe was slightly cloudy and yellow, but the last 10 to 15 ml gradually changed to opaque, purulent, white material with clumps of cells and fibrin. The procedure was atraumatic, the needle was not moved, and the flow of fluid was unimpeded.

A leukocyte count of the entire spec-

The authors are associated with the University of Pennsylvania School of Medicine and the Philadelphia Veterans Administration Hospital, Philadelphia. *Dr. Hasselbacher is supported in part by a postdoctoral fellowship of the American Rheumatism Association.*

imen was 43,000/mm³ with 92 percent neutrophils. No crystals were seen, and cultures were negative. No definite diagnosis was possible despite careful followup. Slow resolution occurred.

Case # 3

A 65-year-old coal miner with a history compatible with rheumatoid arthritis developed increasing pain and swelling in the right knee. The condition was treated conservatively elsewhere for about 8 weeks. The knee was warm, tender, and grossly distended with effusion.

The aspirating needle was inserted medially beneath the patella and 100 ml of slightly cloudy yellow fluid was obtained. The suprapatellar area remained very swollen, so the needle was partially withdrawn and advanced more superiorly. Surprisingly, another 50 ml of foul smelling, opaque, chocolate-colored fluid was aspirated in a new syringe.

The leukocyte count from the first fluid was 10,000/mm³ with 98 percent neutrophils. The gram stain was negative. The leukocyte count of the second fluid was in excess of 100,000/mm³ and gram stain demonstrated gram-positive cocci in pairs and clusters.

Cultures of both fluids grew out *Staph aureus*. Compartmentalization of the synovial fluid by fibrous adhesions was thought to be responsible for the difference in the fluids.

We are not aware that this phenomenon has ever been emphasized, and have found no comment in discussions of the procedure of arthrocentesis and synovial fluid analysis in authoritative sources.[2-5] Although the fluids from the first two patients were collected in single syringes, the change in character of the fluid was gradual, with a marked change from mildly inflammatory to grossly purulent. Unlike the procedure with the third patient, there was no change in needle position or rate of flow to suggest that loculation of fluid had occurred.

Effect of sedimentation

When synovial fluid is allowed to sit in test tubes *in vitro*, sedimentation of the cells and other particulate material is apparent within a few hours, depending on the viscosity of the fluid (*unpublished observation*). There is no reason not to expect the same phenomenon to occur *in vivo*. Cells and particulate material would then accumulate in dependent portions of the joint.

Ordinarily, arthrocentesis immediately follows physical examination during which the joint is put through its range of motion. In the circumstances described, the involved joints were immobile for a period of several hours before aspiration. Had these joints been incompletely aspirated, a falsely low leukocyte count would have resulted.

There is a natural tendency to use the initial fluid for cytologic and chemical studies, since near the end of arthrocentesis, as the joint space closes, blood often appears in the syringe from the trauma of the needle. As we have illustrated, under some circumstances this practice may underestimate the intrasynovial leukocyte count.

Complete aspiration of a joint is indicated in virtually all arthrocenteses to remove leukocytes, products of inflammation, and crystalline material causing inflammation, and to reduce intra-articular pressure. In some situations, movement of the joint may be indicated before aspiration to ensure adequate sampling.

Compartmentalization of synovial fluid in septic arthritis is often considered to be an indication for surgical drainage of an infected joint.[6] The frequency of this occurrence is unknown, but in all likelihood is quite rare. We have not encountered a second case of loculation in our large medical center for over three years. Care must be taken that sedimentation of the synovial contents is not confused with loculation. □

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Know your taxes

New jobs tax credit reduces hiring costs in 1977-78

Donald L. DeMuth, M.B.A., C.P.A.
Edward H. Achorn, M.Adm., C.P.A.

Physicians adding employes this year or last or physicians starting practice within that time period may find the cost of hiring is less than they expected. Uncle Sam is picking up part of the tab via a tax credit to encourage fuller employment. This credit applies to any new employes, including physicians. For many practitioners, this could be the biggest tax savings device of the year.

Determining tax credit

Examine the general rules used to determine the credit:

1. Multiply the first $4,200 earned in 1977 by number of employes. If an employe has earned less than $4,200 this year, add the actual amount he earned to the previous product.
2. Make the same calculation for 1976 wages and salaries.
3. Multiply the 1976 figure by 1.02 and subtract this from the 1977 computation. Multiply the difference by 50 percent.

If a physician had three aides in 1976 who earned $7,500 each and added a fourth aide who earned $6,000 in 1977, he stands to benefit from the credit as shown in Table 1.

Table 1.
Computation of New Jobs Tax Credit

First $4,200 earned × 4 employes in 1977		$16,800
First $4,200 earned × 3 employes in 1976	12,600	
	×1.02	12,852
		$ 3,948
		×50%
1977 new jobs tax credit		$ 1,974

Remember, this is a credit, not a deduction. A credit is subtracted directly from the *tax* computed, whereas a deduction is subtracted from *income* to determine taxable income.

The example is not complete at this point. Uncle Sam is part Indian giver with the new jobs tax credit. He requires that the taxpayer *subtract* the *credit* from *salaries and wages* before computing taxable income. Essentially, the doctor is increasing his taxable *income* by the credit as illustrated in Table 2.

In this case, taxable income increased by $1,974, the amount of the new jobs tax credit. Despite this, the tax payable was virtually $1,000 less when the credit was applicable.

In line with a progressive income tax system, the credit is designed to help those in lower tax brackets more than those in higher brackets. Although Congress did not intend this outcome, professional corporations, which should almost always be in the 20 percent tax bracket, will benefit more from the credit than unincorporated practitioners, who are invariably in brackets above 20 percent.

There are provisions to carry the new jobs tax credit back for up to three years and forward up to seven years. If it exceeds the amount of tax computed this year, however, the incorporated physician may prefer to keep some income in the corporation to use the credit and pay out the earnings retained, or a portion, as a dividend.

This helps dispel an IRS unreasonable compensation attack that part of the income paid the physician is a dividend for his stock investment. Also, since the credit keeps the corporation from paying tax on the income, the "double taxation" argument against paying dividends is overcome. Before making this sort of decision, the physician should consult his tax advisor.

Mr. DeMuth is assistant professor of accounting and finance and Mr. Achorn is assistant professor of accounting and management at The Pennsylvania State University's Capitol Campus, Middletown.

Table 2.
Tax When Credit Is or Is Not Applied

Credit not applied		
Taxable income before salaries and wages		$80,000
Salaries and wages (no new 1977 employes)		28,500
Taxable income		$51,500
Income tax[1]		$17,630
Credit applied		
Taxable income before salaries and wages		$80,000
Salaries and wages	28,500	
New jobs tax credit	−1,974	
Salaries and wages deductible		26,526
Taxable income		$53,474
Income tax[1] on $53,474		$18,608
New jobs tax credit		−1,974
Income tax payable		$16,634

[1]The tax is computed assuming the doctor is a married, unincorporated practitioner.

Wage limitation

To prevent a potentially dysfunctional abuse of the new jobs tax credit,

Congress included a wage limitation on the credit. After computing the credit, it cannot exceed 50 percent of the difference between the 1977 payroll and 105 percent of the 1976 salaries and wages. An example follows to illustrate the wage limitation. Table 3 demonstrates the computations involved.

Table 3. Computation of Tentative Credit and Wage Limitation

Tentative credit		
First $4,200 earned × 6 employes in 1977		$25,200
First $4,200 earned × 3 employes in 1976	12,600	
	× 1.02	12,852
		$12,348
		× 50%
Tentative new jobs tax credit		$ 6,174
Wage limitation		
1977 total payroll		$29,400
1976 total payroll	25,200	
	× 1.05	26,460
		$ 2,940
		× 50%
1977 new jobs tax credit allowed		$ 1,470

A family practitioner has three aides who earned $8,400 each in 1976. Halfway through 1977, two of the aides leave. He replaces the two and hires a fourth aide. All are paid $8,400 per year. At the end of the year the new jobs tax credit is computed. The physician had six employes who earned at least $4,200 in 1977—the aide employed the entire year, the two who departed during the year, their two replacements, and the aide in the new position.

When the credit was initially computed, the $6,174 credit was greater than the $4,200 increase in the total aides payroll—an enviable but unrealistic position. The physician was treated as having six employes for credit computation purposes, even though he had at most four employes at any one time. This caused the too-good-to-be-true tentative credit. The wage limitation test held the credit to $1,470.

There is also a $100,000 ceiling on the new jobs tax credit. It is a rare practice that need concern itself with this limitation.

Thus far the article has indicated how the established practitioner with more employes this year than last can benefit from the new jobs tax credit. But how can the new physician just beginning private practice take advantage of it?

Rapidly expanding business limitation

For practices in which the first $4,200 earned by each employe this year times 50 percent is greater than the first $4,200 earned the previous year times 102 percent (which certainly applies to the new practitioner), there is a limit to the amount of the credit that can be taken. The credit is limited to 25 percent of the first $4,200 earned per employe in the current year.

For example, an internist starting practice in 1978 hires two aides and pays each $7,000 during the year. The first $4,200 paid each aide times 50 percent is greater than 102 percent times the first $4,200 earned in 1977, since neither aide was employed by him in 1977. His credit is $2,100 as determined in Table 4.

Table 4. Rapidly Expanding Business Limitation

First $4,200 earned × 2 employes in 1978		$8,400
First $4,200 earned × 0 employes in 1977	0	
	× 102%	0
		$8,400
Rapidly expanding business limitation		× 25%
1978 new jobs tax credit		$2,100

The rapidly expanding business limitation applies to established practitioners as well as the fledgling practitioner. It is apt to apply most often to the physician hanging his shingle for the first time.

The doctor who increased the number of his employes in 1977 will benefit from this change in the tax law. And others can plan for this when increasing their staffs in 1978, for the credit is for 1977 and 1978.

The new jobs tax credit could prove to be the biggest tax bonanza for the medical practitioner in the Tax Reduction and Simplification Act of 1977. □

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Roosevelt Approves Message Intended to Benefit 30,0 Persons When States Adopt Cooperating Laws—H the Measure 'Cornerstone' of His Economic Prog

WASHINGTON, Aug. 1, The Social Security Bill, a broad program of unem insurance and old age and counted upon to be 20,000,000 persons, beca day when it was signed dent Roosevelt in the p those chiefly responsibl ting it through Co

Mr. Roosevelt cal "the cornerstone which is being me s c ple ri

SENATE APPROVES 18-YEAR OLD VOTE IN ALL ELECTIONS

Amendment to Constitution is Sent to House, Where Passage is Expected

WASHINGTON, March 10, 1971—The Senate approved today, 94 to 0, and sen

TRUMAN CLOSES ITED NATIONS CONFEREN WITH PLEA TO TRANSLATE CHARTER INTO DEEDS

NEW WORLD HOPE

President Hails 'Great Instrument of Peace,' Insists It Be Used

HISTORIC LANDMARK

Meeting Gives Standing Ovation as Executive Pictures Peace Gain

"If we fail to use it," he declared to the solemn final meeting of the delegates, 'we shall betray all of those who have died in order that we might meet here in freedom and safety to create it.'

"If we seek to use it selfishly—for the advantage of any one nation or any small group of nations—we shall be equally guilty of that betrayal."

Fervent Interpolation

The President, speaking in the auditorium of the War Memorial Opera House, built in memory of sons of the Golden Gate city who gave their lives in the first World War, in which he himself served, seemed to give unconscious expression to the solemn feeling of the occasion when, at the outset of his speech, he interpolated the words, half a hope, half a prayer:

"Oh, what a great day this can be in history!"

Just before the plenary session the President accompanied the

SIGN

the Dra Ends N

WASHINGTON, Jan. 27, 1973—"With the signing of the peace agreement in Paris today, and after receiving a report from the Secretary of the Army that



PATIENT PACKAGE INSERTS: A CONCEPT WHOSE TIME HAS COME?

The consumer's right to know is an irreversible and desirable trend of the Seventies. It extends, and properly, to a patient's right to know more about his or her prescription medications. One way, gaining favor, is through patient package inserts. Wisely-prepared and properly distributed when medically indicated, they could markedly improve patient knowledge and drug therapy—laudable goals by anyone's standards.

The PMA endorses these goals and will work with government, the health professions and consumers to achieve them.

The Advantages

The concept holds promise of benefits: better patient understanding of the product prescribed, better adherence to the treatment plan, and more awareness of possible side reactions.

Every doctor has had patients who fail to finish antibiotic regimens because they feel better. Some patients assume that if one tranquilizer or analgesic is good, two may be twice as good. Still others fail to report dizziness while on antihypertensive therapy —and so on.

Problems like these might arise less often if the patient received written information in addition to verbal instructions. Some studies suggest that patients are more receptive to such materials, and they more often understand the verbal instructions and follow them, when inserts are used.

The Disadvantages

There are also some potential problems. Obviously, the inserts must be clearly phrased, without extraneous or complex detail. How much information is enough? How can it be kept current? Should all patients receive the same information? Should inserts be included with all drugs? Should only potential problems be listed or are patients better off with a "fair balance" presentation that describes usefulness as well as drawbacks?

These and similar questions require answers, since model inserts have yet to be properly developed and tested. Despite the need for these studies, the FDA is proceeding prematurely with inserts on selected products. We think the Congress is the only place where the matter can be given the proper legal status and direction, particularly since it represents a conceptual change in the legal, medical and social framework of the nation's prescription drug information system.

The Solution

The PMA believes that carefully-devised pilot studies of various kinds of inserts are needed. They should be developed and implemented with full participation by doctors, pharmacists, consumers, communications experts and the drug industry. Such studies will provide reliable pathways to follow, so that inserts will be useful aids to medical practice.

And particularly we think that you should be closely involved in this debate and in these studies and decisions. Otherwise, people with less experience and qualifications may control the purposes, content and use of a tool with considerable promise for improved patient care. It could make a difference in your practice tomorrow, and more importantly, in the health of your patients.

PMA
THE PHARMACEUTICAL MANUFACTURERS ASSOCIATION
1155 FIFTEENTH ST., N. W., WASHINGTON, D. C. 20005

Hospital rounds nurse concept expanded, evaluated

Joel H. Merenstein, M.D.
Donna Maria Barbaro
Kathleen M. Barker
Harvey Wolfe, Ph.D.

Extended roles for nurses have been developed in an attempt to improve the quality of nursing practice and overcome deficiencies in patient care. Foremost among these have been the clinical nurse specialist and the nurse practitioner.[1] Although there are many variations in functions and responsibilities, the emphasis in the extended role is on a highly trained individual who relates to the patient and various other professionals as a decision maker.

Combining some of the skills and functions of both these nursing specialists, we developed the concept of a hospital rounds nurse (HRN) who works with a group of physicians and aids patients and families in adjusting to hospitalization. Such an individual assumes some of the duties of a clinical nurse specialist while maintaining an expediting and liaison role with the physicians. The nurse is not a hospital employe but is based in the physician's office and regularly makes rounds to his hospitalized patients.

In a previous experiment, patients reported satisfaction with office-based nurses supplementing physicians' hospital visits.[2] Patients noted that they could communicate to the nurse information they "would not want to bother the doctor with." In addition, they were able to identify the office-based nurse in the hospital as a representative of their physician and deemed this beneficial.

The study reported here expands this experience to a larger volume of patients and physicians. In addition to describing the actual and proposed functions of the HRN, measurements of patients' and professionals' satisfaction are reported.

Procedures

The individual selected as the HRN held a Masters degree with a major in community health nursing and a minor in psychology. She had experience as a pediatric nurse, a charge nurse, and a float nurse in a community hospital. Prior to the project she was a faculty member in a baccalaureate nursing program. She was selected because of her educational background and her availability for a one-year experimental trial.

The group of physicians involved in testing the HRN concept is a multispecialty medical group of 17 full-time physicians and an equal number of part-time consultants. The group uses four office locations but only one hospital.

The hospital is a 225-bed facility providing short-term acute care and a full range of routine services, including a small (one and a half person) social service department. The hospital has no house staff.

In preparation for her role, the HRN attended a formal lecture and preceptor training course conducted by the group for nurse practitioners to function in an expanded role with ambulatory patients. The program included a weekly psychological medicine seminar with the staff's consulting psychiatrist. A training schedule specific to the hospital complemented the formal course.

Several meetings were held with the medical group physicians to famil-

Dr. Merenstein is clinical associate professor of community medicine at the University of Pittsburgh and during this study was medical director of the Russellton Medical Group, New Kensington. Ms. Barbaro, Ms. Barker, and Dr. Wolfe are associates in the research department of Blue Cross of Western Pennsylvania. *This study was supported in part by a grant from The Pittsburgh Foundation.*

iarize them with the concept and the ideal use of the HRN. Because this was to be an experimental program, the physicians were divided into control and experimental groups. An attempt was made to balance the groups by specialty, number of patients hospitalized, and length of stay.

The HRN was assigned half time to hospital patients and half time as an office nurse practitioner. It was important at this time for the HRN as well as the patients and other professionals to view her position as essentially office based. At the outset of the experiment, the HRN was to see all hospitalized patients of physicians in the experimental group. It became clear during the early phases of the project that it was not possible to reach this goal. The HRN then saw only patients referred by physicians in the experimental group.

To evaluate the role of the HRN, key professionals were interviewed and patient satisfaction was measured by means of a standard questionnaire. The questionnaire used was an adaptation of the checklist for inpatients' satisfaction with hospital care developed by Abdellah and Levine.[3] Because the questionnaires were to be completed by individuals after their hospital stay, changes in the form and content of questions were made. The procedure of using general questions relating to satisfaction was maintained. No specific questions about the HRN were included.

The questionnaires were sent to 233 patients divided by experimental and control groups of physicians. Each questionnaire was accompanied by a cover letter signed by the patient's physician.

Interviews were designed to determine the reaction of health professionals to the HRN experiment. Those interviewed included the medical director of the group practice, the home health nurse and social worker of the group practice, seven physicians from the experimental group and four from the control group, and all hospital head nurses and supervisors.

The same experienced interviewer

Table 1. Distribution of Returned Questionnaires

Sample groups	*Questionnaires mailed*	*Questionnaires returned*	
	No.	*No.*	*%*
I Patients seen by HRN	47	29	61.7
II Experimental group patients not seen by HRN	47	27	57.4
III Control group	139	89	64.0
Total	233	145	62.2

Table 2. Possible and Actual Complaints

Sample groups	*No. responding*	*Possible complaints*	*Actual complaints*
I Patients seen by HRN	29	957	165 (17.2%)
II Experimental group patients not seen by HRN	27	891	188 (21.10%)
III Control group	89	2,937	468 (15.93%)

conducted all but the nurses' interviews, which were conducted by the medical director of the group practice. Although specific questions were asked, the interviewers maintained an open-ended format in order to avoid leading questions.

Interviewees were asked: Is the concept a good one? Was the experiment a success? Should an HRN be employed on a permanent basis by the group?

Results

Questionnaires—Questionnaires were returned by 62 percent of patients with no significant difference in return rates between experimental and control groups (Table 1). Based on individual questions and on total scores of the questionnaires, no significant difference in patient satisfaction was evident between experimental and control groups (Table 2).

Interviews—Although the interviews revealed some misunderstanding about the functions of the HRN, there was a general consensus about the experiment. All the physicians and staff interviewed (12 physicians, 3 other professionals) felt that the concept had value. Only 25 percent believed the program was successful and few would continue it without substantial changes.

The hospital nurses interviewed separately were the most positive about the HRN, viewing her role as complementary to their own. They found the HRN very helpful, particularly in dealing with the personal needs of patients and families. Most nurses thought the HRN should be employed by the practice rather than the hospital so that she could serve as a representative of the physician and be free of hospital controls.

Although the medical group physicians expressed dissatisfaction with the results of the program, they attributed the outcome to problems with the hospital and to the fact that the program was in effect for too short a period. They felt that there was too little time to become familiar with the new HRN role and to integrate her function into the health care team.

The physicians also thought the HRN was expected to service too many physicians. Because she worked half time in the office and half time in the hospital, she was unable to work closely with all seven physicians in the experimental group.

One physician interviewed expressed concern about the cost effectiveness of employing an HRN. This study did not include an evaluation of the relevant cost benefit factors.

Discussion

Many patients and their families find hospitalization a threatening experience. The concerns of patients anticipating hospital procedures could be alleviated by increased physician understanding of this fear.[4] A study of doctor-patient rapport demonstrated reduction of postoperative pain by encouragement and instruction of patients.[5]

Frequently, however, neither physicians nor nurses perform this function. Hospital patient units continue to be centers of ritualistic nursing in which nurses provide care in accordance with physicians' orders and have their responsibility defined by geography (patient unit) and hours (shift) rather than patient needs.[6] In an evaluation of the quality of care in a major teaching hospital, Duff and Hollingshead reported that social and psychological factors pertinent to illness were ignored by physicians and nurses.[7]

In an attempt to overcome these deficiencies, the role of the clinical nurse specialist was developed. This experiment was conducted in an attempt to expand that role by utilizing an office-based nurse practitioner as a liaison among hospitalized patients, their families, and their attending physicians. The role was seen as particularly relevant in small community hospitals without house staff.

Although the physicians involved accepted the concept of the HRN as a valid one, they generally agreed the program was not successful. While the physicians offered reasons for this failure, there were also suggestions that the physicians did not cooperate fully.

The difficulties encountered in transferring responsibilities from physician to nurse are not new to this study. Ten years ago Levy discussed physicians' concerns of "final medical responsibility," delegation versus surrender of function, and comprehensiveness of function.[8] Bates more recently commented on the disparity between physicians' promises to share in patient care and their actual performance.[9]

Feelings expressed by physicians in a multispecialty group attempting to use the participation of nurses in chronic care were similar to those exhibited in this study and confirm Bates' comments. These authors stated, "The physician's feeling of total responsibility for his patient and of meeting his perception of his patient's needs by himself, or by referral to another physician, is not easy to change. Indeed, some of the physicians expressed anxiety about 'losing' their patients to the nurses and, in many cases, they seem unsure of the abilities of nonphysicians to share the care of patients."[10]

It may be that the definition of the HRN's role contributed to the experiment's failure. Little has pointed out the difficulty of defining a role too broadly, combining nursing tasks as a technical function with total patient care as a decision-making function.[11] This program combined some of the technical tasks of a physician's assistant with the total patient care responsibility of a clinical nurse specialist. With a more reasonable work load and greater physician support, this goal might have been achieved. □

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obituaries

• Indicates membership in the Pennsylvania Society at time of death.

• **Charles A. Callis,** Manheim; Jefferson Medical College, 1949; age 52; died November 22, 1977.

• **John H. Campbell,** Hazleton; Jefferson Medical College, 1941; age 61; died December 3, 1977. He had practiced obstetrics and gynecology in Hazleton for 27 years.

• **John L. Dukes,** Berwyn; University of Pennsylvania School of Medicine, 1901; age 100; died December 10, 1977. He had practiced family medicine in Philadelphia for sixty years.

• **Israel Felman,** Pittsburgh; University of Virginia School of Medicine, 1927; age 76; died November 19, 1977.

• **Marshall W. Graham,** Washington; University of Pittsburgh School of Medicine, 1933; age 70; died December 9, 1977. He had practiced medicine in Washington since 1936 and was the medical director for the Presbyterian Home for the Aged and the Washington Hospital Extended Care Facility.

• **Robert C. Hamilton,** Pittsburgh; University of Pittsburgh School of Medicine, 1927; age 74; died November 26, 1977. He had been a pathologist and director of laboratories at St. Francis General Hospital for thirty years.

• **Arthur C. Hehn,** Pocono Pines; University of Pennsylvania School of Medicine, 1924; age 77; died November 22, 1977. He had been a member of the obstetrics and gynecology staff at Abington Memorial Hospital for 45 years.

• **Raymond G. Hidlay,** Dunmore; Hahnemann Medical College, 1927; age 83; died November 17, 1977. He had practiced medicine in Dunmore for more than fifty years and was a past president of the Lackawanna County Medical Society.

• **Romeo A. Luongo, Sr.,** Philadelphia; University of Bologna, Italy, 1919; age 85; died December 14, 1977. He had practiced otolaryngology in Philadelphia for 52 years.

• **James F. McCahey,** Philadelphia; Jefferson Medical College, 1921; age 84; died November 16, 1977. He had been a urologist and surgeon in the Philadelphia area until his retirement in 1962.

• **Murray F. McCaslin,** Pittsburgh; University of Pittsburgh School of Medicine, 1929; age 73; died December 21, 1977. He was professor emeritus and former chairman of the department of ophthalmology of the University of Pittsburgh and former chief of eye service at Eye and Ear Hospital.

• **William M. Markley,** Pittsburgh; University of Pittsburgh School of Medicine, 1939; age 62; died December 6, 1977.

• **Ralph F. Otterbein,** Warren; University of Pennsylvania School of Medicine, 1922; age 81; died December 28, 1977.

• **Milton M. Perloff,** Philadelphia; Jefferson Medical College, 1952; age 57; died November 22, 1977. He was past president of the Philadelphia and Pennsylvania Academies of Family Practice and former chairman of the medical staff and board of Albert Einstein Medical Center, Northern Division. He was named Practitioner of the Year in 1976 by the Philadelphia County Medical Society and was awarded the 1977 Professional Service Award of the American Society of Clinical Hypnosis.

• **David C. Pewterbaugh,** York; Jefferson Medical College, 1933; age 73; died December 10, 1977. He had practiced pediatrics in York for 32 years.

• **Roland D. Porter,** Coral Gables, Florida; University of Pennsylvania School of Medicine, 1923; age 79; died November 9, 1977. An Athens native, he had served on the gynecology staff at Abington Memorial Hospital and was the hospital's chief of staff for 31 years.

• **Charles T. Provost,** Overbrook; Hahnemann Medical College, 1928; age 72; died December 14, 1977. He had practiced family medicine in the Pittsburgh area for 47 years.

• **Lynn M. Rankin,** Clearwater, Florida; Jefferson Medical College, 1921; age 81; died November 20, 1977. He had served in the department of surgery at Delaware County Memorial Hospital for 35 years and was a former director of surgery at the hospital.

• **Frank W. Riley,** Greentown; Georgetown University School of Medicine, 1936; age 72; died November 17, 1977. He was a native of Scranton, where he practiced surgery for more than thirty years.

• **Frederick Rock,** Pittsburgh; University of St. Louis School of Medicine, 1932; age 69; died November 19, 1977. He had practiced ophthalmology for 44 years.

• **Harry A. Sapira,** Pittsburgh; University of Pittsburgh School of Medicine, 1931; age 70; died December 1, 1977. He had practiced medicine in Pittsburgh for 46 years until his retirement in 1976.

• **Samuel K. Schultz,** Johnstown; Jefferson Medical College, 1934; age 69; died November 14, 1977. He had served as president of Memorial Hospital's medical staff and as the hospital's associate chief of obstetrics and gynecology.

• **J. Russell Sweeney,** Allentown; University of Pennsylvania School of Medicine, 1921; age 81; died November 27, 1977. He had been a practicing physician in Tamaqua for more than fifty years and was a past president of the Lehigh Valley and Carbon-Schuylkill Medical Societies.

• **Arthur A. Sweetser, Jr.,** Sellersville; Jefferson Medical College, 1945; age 59; died December 9, 1977.

• **John A. Tamarelli,** Pittsburgh; Hahnemann Medical College, 1938; age 68; died December 2, 1977.

• **John T. Warrington, Jr.,** Ridley Park; Hahnemann Medical College, 1966; age 37; died November 23, 1977.

• **Norman D. Weiner,** Philadelphia; Hahnemann Medical College, 1958; age 45; died December 2, 1977. He had been clinical associate professor of psychiatry at Hahnemann Medical College.

• **George J. Willauer,** Philadelphia; Jefferson Medical College, 1923; age 81; died December 19, 1977. He was a well known surgeon and educator who was a pioneer of vascular surgery and the inventor of several surgical instruments. He was founder and past president of the Ex-Residents Association of Jefferson Medical College, the Jefferson Society for Clinical Investigation, and the Lennec Society. He had been clinical professor of surgery at Jefferson and was made honorary professor in 1961.

W. Earl Biddle, Philadelphia; Jefferson Medical College, 1935; age 71; died December 18, 1977. Dr. Biddle had been clinical director at Philadelphia State Hospital at Byberry until his retirement in 1973. He had also directed the mental hospital's north unit and headed its department of religious affairs from 1954 until his retirement. He served as assistant superintendent of Wernersville State Hospital from 1947 to 1954 and as a staff psychiatrist at Warren State Hospital from 1936 to 1947. Dr. Biddle was among the pioneers in "image therapy," in which patients are encouraged to give form on paper to their mental images.

Anthony L. Frye, Carmel, California; Hahnemann Medical College, 1936; age 67; died November 13, 1977. He had practiced medicine in Sharon for several years and had helped organize the Sharon Medical Center.

Arthur R. Gaines, Denver, Colorado; Jefferson Medical College, 1916; age 85; died November 18, 1977. Dr. Gaines was a retired Army major general and former medical director of the Henry R. Landis State Tuberculosis Hospital in Philadelphia.

Georgiana W. Jackson, Kennett Square; Medical College of Pennsylvania, 1902; age 99; died November 16, 1977.

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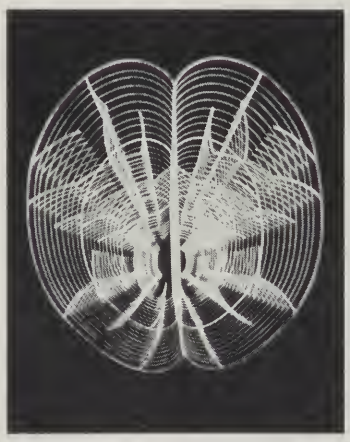
Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs



such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

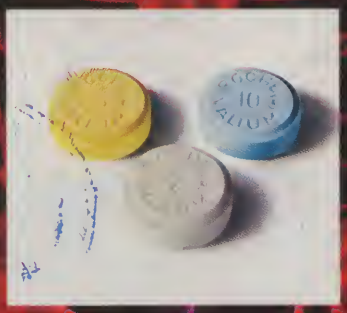
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Medical-Legal Aspects of the Doctor-Patient Relationship

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Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Warn patients that mental and/or physical abilities required for tasks such as driving or operating machinery may be impaired, as may be mental alertness in children, and that concomitant use with alcohol or CNS depressants may have an additive effect. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

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STATE SOCIETY LOBBIES ON COST CAP LEGISLATION

The State Society lobbied in Washington, DC on February 23 against a new version of hospital cost containment legislation which threatens the voluntary effort to control costs even before it has a fair test. Representative Dan Rostenkowski, whose challenge prompted voluntary cost containment planning by the AMA, the American Hospital Association, and the Federation of American Hospitals, is sponsor of the legislation.

The legislation would provide a federal hospital revenue "cap" which would take effect immediately if the voluntary program failed to meet the cost restriction in the bill for any year. Joseph V. Caliguiri, M.D., of Pittsburgh, and William D. Lamberton, M.D., of Erie, met with Pennsylvania congressmen on the House Ways and Means Committee, as well as with representatives of other state medical societies.

HEALTH PLANNING AMENDMENTS MOVING

Amendments to the National Health Planning and Resources Development Act have been introduced in both houses of Congress. Among the amendments is one requiring a certificate of need for diagnostic and therapeutic equipment exceeding $150,000 in cost irrespective of its location. This would include physicians' offices.

Representatives of organized medicine lobbied against this proposal while in Washington February 23, and urged consideration for the AMA's amendments to the Act. These include providing for proper "direct provider" representation on HSA boards, making certificate of need a state option rather than mandatory, and preventing the extension of certificate of need to physicians' offices.

PMS-HAP FORM COST TASK FORCE

The State Society and the Hospital Association of Pennsylvania (HAP) are cooperating to form a task force on cost containment as part of the nationwide voluntary cost containment effort mounted by the AMA and the American Hospital Association. One of its first tasks is planning a June 1 and 2 conference on health care costs which will include representatives from business, organized labor, insurance companies, and the general public. The conference will study health care costs and probe for ways to keep costs in check.

SOCIETY RECOMMENDS ON FLUOROSCOPY

The Pennsylvania Medical Society in a letter to Thomas Tierney, director of the Bureau of Health Insurance, has recommended that office fluoroscopy no longer be reimbursed by medicare. The action, approved by the Board of Trustees January 25, was initiated by the Society's Internal Medicine Advisory Committee. Concern over the quality of medical care provided and the cost of that care motivated the committee to pursue the action.

CREDIT UNION RECEIVES CHARTER

Formal presentation of the charter of the Pennsylvania Medical Society Credit Union took place on February 16. Membership is open to all Society members; Auxiliary members; and employes of members, the State Society and its affiliated organizations, and county medical societies. Spouses and immediate family members of those listed above also are eligible for membership. See the announcement on page 58 of this issue for further information.

DEMARCO HEARING RESET FOR MARCH 14

The State Board of Medical Education and Licensure will conduct a hearing March 14 in Philadelphia for Peter T. DeMarco, M.D., currently of Morrisville, PA, who lost his New Jersey license January 12. He was fined $20,200 for gross malpractice in causing a hepatitis outbreak by using unsterilized needles and syringes. The Pennsylvania hearing originally was scheduled for January 30. Meantime, the Pennsylvania Department of Health has placed controls on Dr. DeMarco and has placed an embargo on his supply of Procaine-PVP.

SUBCOMMITTEE TO HANDLE SOCIETY'S COST EFFORTS

The Board of Trustees has authorized a subcommittee of the Council on Medical Service be responsible for the Society's participation in "Voluntary Effort," the health care cost containment program of the AMA, the American Hospital Association, and the Federation of American Hospitals. Subcommittee members are: Henry H. Fetterman, M.D., of Allentown, chairman of the Council on Medical Service; Paul F. Kase, M.D., Harrisburg; Webb S. Hersperger, M.D., Carlisle; and Joseph M. Stowell, M.D., Altoona, Board of Trustees representative on the Council.

ASSESSMENT FOR PMSLIC OVER $8 MILLION MARK

Over 11,000 members (94 percent) have paid assessments to provide start up funds for the Pennsylvania Medical Society Liability Insurance Company. Over $8 million has been collected. This is the amount set as a goal by the Board of Trustees in September 1977 when the assessment was announced.

INVESTIGATORS SOUGHT FOR PROFESSIONAL BOARDS

The Bureau of Professional and Occupational Affairs has announced it will hire 12 people to serve as State Professional Conduct Investigators. Applications are being accepted through April 17 by Peter C. Storie, Pennsylvania Department of State, Personnel Management Division, Room 309, North Office Building, Harrisburg, PA 17120.

The new position has a salary range from $12,029 to $15,609 The investigators will be involved in checking details of complaints lodged against health care professionals licensed by the Bureau of Professional and Occupational Affairs, including the State Board of Medical Education and Licensure

Pennsylvania Medicine

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MARCH 1978 Volume 81, Number 3

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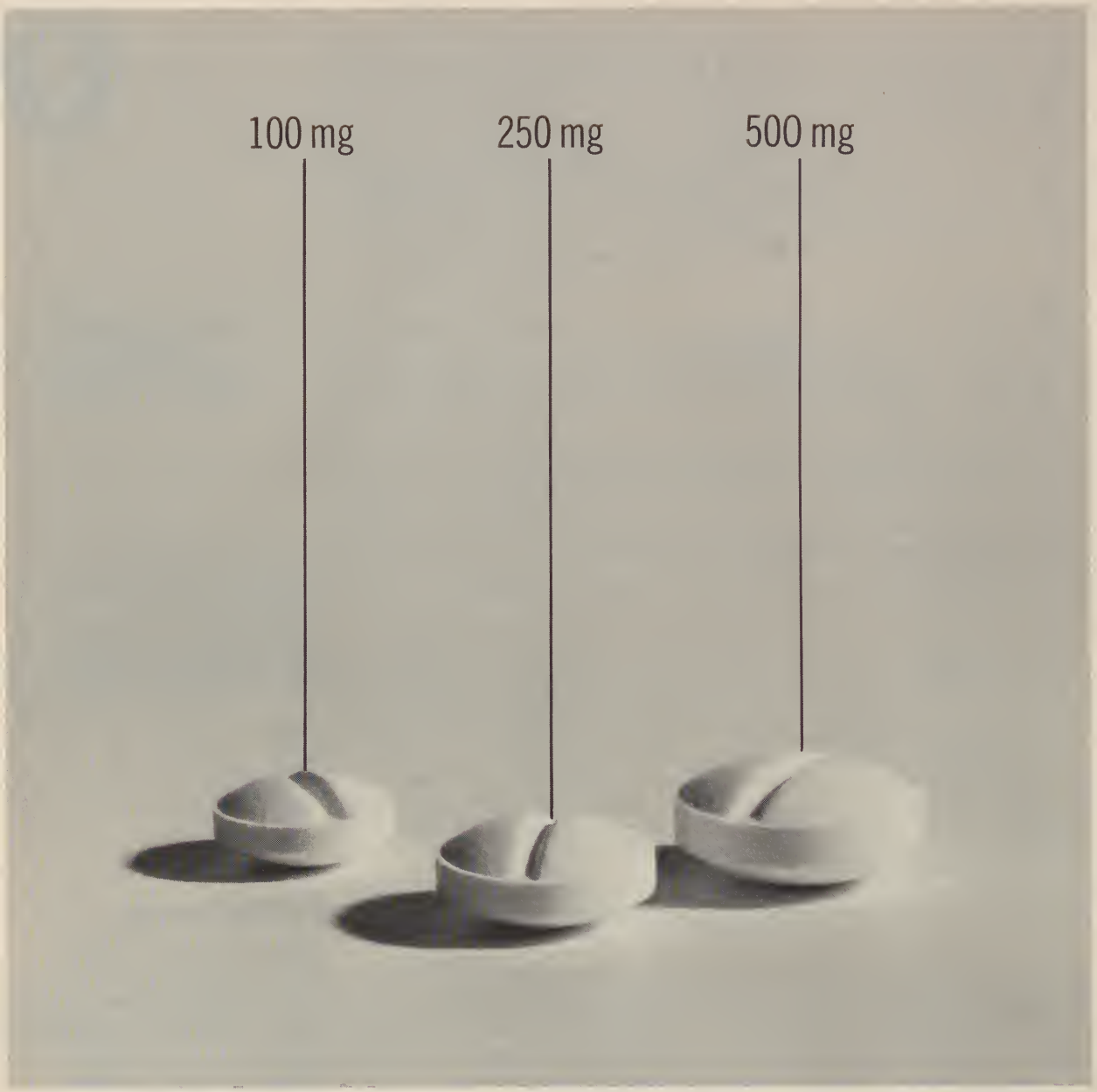
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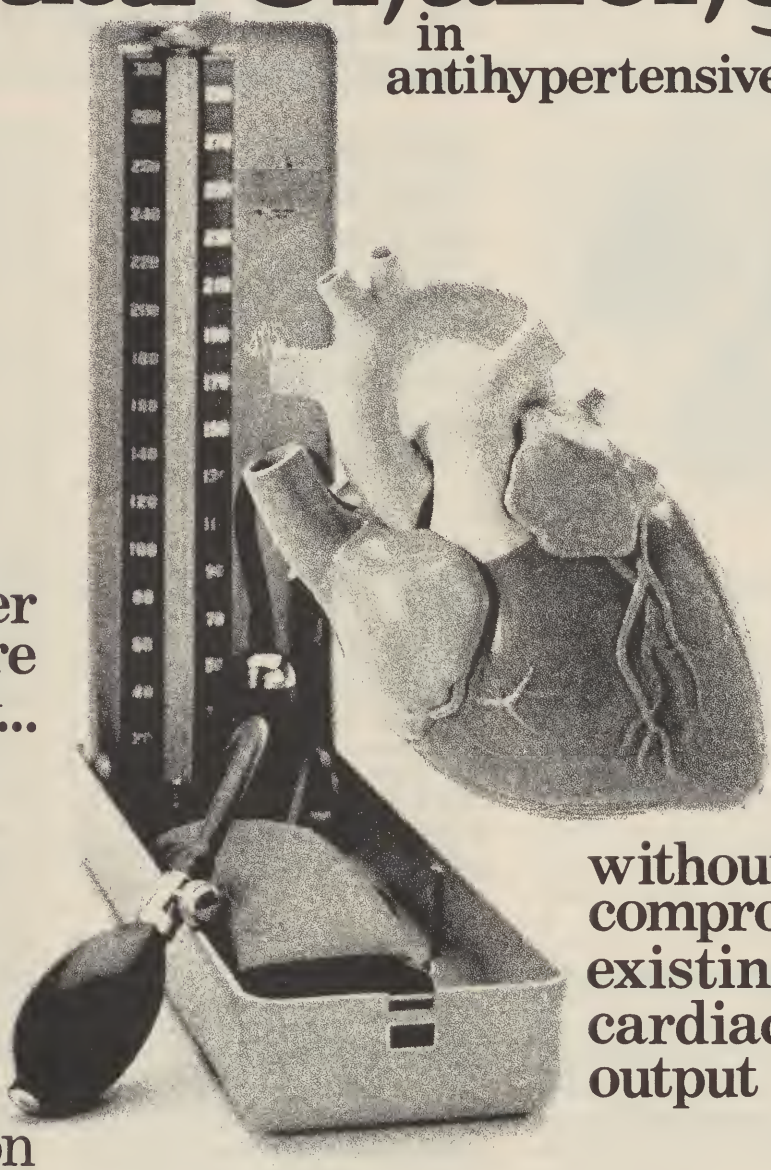
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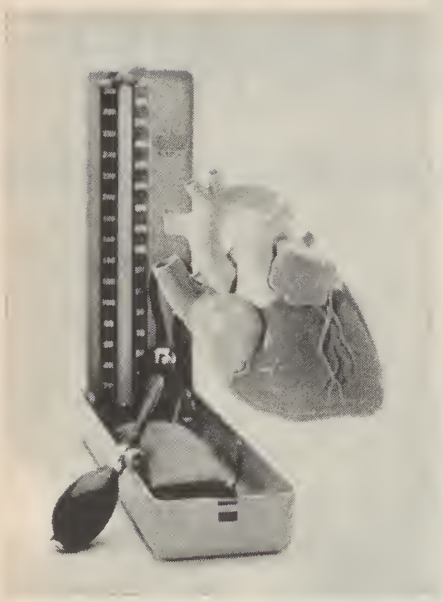
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It is important to recognize that a positive Coombs test, hemolytic anemia, and liver disorders may occur with methyldopa therapy. The rare occurrences of hemolytic anemia or liver disorders could lead to potentially fatal complications unless properly recognized and managed. For more details see the brief summary of prescribing information.

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Warnings: It is important to recognize that a positive Coombs test, hemolytic anemia, and liver disorders may occur with methyldopa therapy. The rare occurrences of hemolytic anemia or liver disorders could lead to potentially fatal complications unless properly recognized and managed. Read this section carefully to understand these reactions.

With prolonged methyldopa therapy, 10% to 20% of patients develop a positive direct Coombs test, usually between 6 and 12 months of therapy. Lowest incidence is at daily dosage of 1 g or less. This on rare occasions may be associated with hemolytic anemia, which could lead to potentially fatal complications. One cannot predict which patients with a positive direct Coombs test may develop hemolytic anemia. Prior existence or development of a positive direct Coombs test is not in itself a contraindication to use of methyldopa. If a positive Coombs test develops during methyldopa therapy, determine whether hemolytic anemia exists and whether the positive Coombs test may be a problem. For example, in addition to a positive direct Coombs test there is less often a positive indirect Coombs test which may interfere with cross matching of blood.

At the start of methyldopa therapy, it is desirable to do a blood count (hematocrit, hemoglobin, or red cell count) for a baseline or to establish whether there is anemia. Periodic blood counts should be done during therapy to detect hemolytic anemia. It may be useful to do a direct Coombs test before therapy and at 6 and 12 months after the start of therapy. If Coombs-positive hemolytic anemia occurs, the cause may be methyldopa and the drug should be discontinued. Usually the anemia remits promptly. If not, corticosteroids may be given and other causes of anemia should be considered. If the hemolytic anemia is related to methyldopa, the drug should not be reinstituted. When methyldopa causes Coombs positivity alone or with hemolytic anemia, the red cell is usually coated with gamma globulin of the IgG (gamma G) class only. The positive Coombs test may not revert to normal until weeks to months after methyldopa is stopped.

Should the need for transfusion arise in a patient receiving methyldopa, both a direct and an indirect Coombs test should be performed on his blood. In the absence of hemolytic anemia, usually only the direct Coombs test will be positive. A positive direct Coombs test alone will not interfere with typing or cross matching. If the indirect Coombs test is also positive, problems may arise in the major cross match and the assistance of a hematologist or transfusion expert will be needed.

Fever has occurred within first 3 weeks of therapy, occasionally with eosinophilia or abnormalities in liver function tests, such as serum alkaline phosphatase, serum transaminases (SGOT, SGPT), bilirubin, cephalin cholesterol flocculation, prothrombin time, and bromsulphalein retention. Jaundice, with or without fever, may occur, with onset usually in the first 2 to 3 months of therapy. In some patients the findings are consistent with those of cholestasis. Rarely fatal hepatic necrosis has been reported. These hepatic changes may represent hypersensitivity reactions; periodic determination of hepatic function should be done particularly during the first 6 to 12 weeks of therapy or whenever an unexplained fever occurs. If fever and abnormalities in liver function tests or jaundice appear, stop therapy with methyldopa. If caused by methyldopa, the temperature and abnormalities in liver function characteristically have reverted to normal when the drug was discontinued. Methyldopa should not be reinstituted in such patients.

Rarely, a reversible reduction of the white blood cell count with primary effect on granulocytes has been seen. Reversible thrombocytopenia has occurred rarely. When used with other antihypertensive drugs, potentiation of antihypertensive effect may occur. Patients should be followed carefully to detect side reactions or unusual manifestations of drug idiosyncrasy.

Pregnancy and Nursing: Use of any drug in women who are or may become pregnant or intend to nurse requires that anticipated benefits be weighed against possible risks; possibility of fetal injury or injury to a nursing infant cannot be excluded. Methyldopa crosses the placental barrier, appears in cord blood, and appears in breast milk.

Precautions: Should be used with caution in patients with history of previous liver disease or dysfunction (see Warnings). May interfere with measurement of: urinary uric acid by the phosphotungstate method, serum creatinine by the alkaline picrate method, and SGOT by colorimetric methods. Since methyldopa causes fluorescence in urine samples at the same wavelengths as catecholamines, falsely high levels of urinary catecholamines may be reported. This will interfere with the diagnosis of pheochromocytoma. It is important to recognize this phenomenon before a patient with a possible pheochromocytoma is subjected to surgery. Methyldopa is not recommended for patients with pheochromocytoma. Urine exposed to air after voiding may darken because of breakdown of methyldopa or its metabolites.

Stop drug if involuntary choreoathetotic movements occur in patients with severe bilateral cerebrovascular disease. Patients may require reduced doses of anesthetics; hypotension occurring during anesthesia usually can be controlled with vasopressors. Hypertension has recurred after dialysis in patients on methyldopa because the drug is removed by this procedure.

Adverse Reactions: *Central nervous system:* Sedation, headache, asthenia or weakness, usually early and transient; dizziness, lightheadedness, symptoms of cerebrovascular insufficiency, paresthesias, parkinsonism, Bell's palsy, decreased mental acuity, involuntary choreoathetotic movements; psychic disturbances, including nightmares and reversible mild psychoses or depression.

Cardiovascular: Bradycardia, aggravation of angina pectoris. Orthostatic hypotension (decrease daily dosage). Edema (and weight gain) usually relieved by use of a diuretic. (Discontinue methyldopa if edema progresses or signs of heart failure appear.)

Gastrointestinal: Nausea, vomiting, distention, constipation, flatus, diarrhea, mild dryness of mouth, sore or "black" tongue, pancreatitis, sialadenitis.

Hepatic: Abnormal liver function tests, jaundice, liver disorders.

Hematologic: Positive Coombs test, hemolytic anemia. Leukopenia, granulocytopenia, thrombocytopenia. Positive tests for antinuclear antibody, LE cells, and rheumatoid factor.

Allergic: Drug-related fever, lupus-like syndrome, myocarditis.

Other: Nasal stuffiness, rise in BUN, breast enlargement, gynecomastia, lactation, impotence, decreased libido, dermatologic reactions including eczema and lichenoid eruptions, mild arthralgia, myalgia.

Note: Initial adult dosage should be limited to 500 mg daily when given with antihypertensives other than thiazides. Tolerance may occur, usually between second and third months of therapy; increased dosage or adding a diuretic frequently restores effective control. Patients with impaired renal function may respond to smaller doses. Syncope in older patients may be related to increased sensitivity and advanced arteriosclerotic vascular disease; this may be avoided by lower doses.

How Supplied: Tablets, containing 125 mg methyldopa each, in bottles of 100; Tablets, containing 250 mg methyldopa each, in single-unit packages of 100 and bottles of 100 and 1000; Tablets, containing 500 mg methyldopa each, in single-unit packages of 100 and bottles of 100 and 500.

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Officers' Conference pinpoints Society's priorities

A diverse program emphasizing the relationship between government and medicine will be offered at the 1978 Officers' Conference on Wednesday and Thursday, April 12-13, at the Hershey Motor Lodge in Hershey.

Greetings by Officers' Conference chairman J. Mostyn Davis, M.D., Wednesday afternoon will be followed by a series of updates on PMS activities. John J. Runzer, Esq., of the law firm of Pepper Hamilton & Scheetz, the Society's legal counsel, will discuss the status of organized medicine in light of the FTC's recent antitrust actions.

John V. Blady, M.D., State Society president, will moderate a panel discussion of key issues facing the Society in 1978. An update of the status of PMS litigation by Fred Speaker, Esq., a partner in the firm of Pepper Hamilton & Scheetz, will follow.

The State Society's legislative priorities will be examined by R. William Alexander, M.D., chairman of the Council on Governmental Relations, and by lobbyists Robert Craig, Jr., and Jerry Rothenberger. "The Anatomy of the Legislature," a multimedia slideshow illustrating the passage of a bill through the legislature, also will be presented.

A reception followed by dinner will be held Wednesday evening. The scheduled speaker is humorist James H. Boren, president of the International Association of Professional Bureaucrats and author of "When in Doubt, Mumble." Although his approach to the subject of bureaucracy is quite obviously a spoof, Boren believes that viewing the problem with humor may lead to improvements. Boren is chairman of the board of NAVCO, a design and engineering firm, and serves as a consultant to several governmental agencies.

Donald H. Reigel, M.D., chief of neurosurgery at Children's Hospital in Pittsburgh, will be guest speaker at a prayer breakfast on Thursday morning. Dr. Reigel will examine the ethical dilemmas created by the advancement of medical knowledge.

Further status reports, by Paul F. Abrams, Esq., administrator of the Office of Medical Malpractice Arbitration, on Act 111; and by David S. Masland, M.D., president of PMSLIC, on the newly formed insurance company, will follow the breakfast.

Larry Altman, M.D., of the *New York Times,* will give the annual Walter F. Donaldson Memorial Lecture on "How the Press Sees Us."

Also included in the Officers' Conference program will be: a slideshow entitled "A Word from Our Sponsor," presenting a series of one-minute commercials on new services and directions of the Society, including resident physician and medical school sections, physician placement, hospital medical staffs, the credit union, unsecured loans, the Co-op, and PMSLIC; introduction of the PMS Department for Specialty Societies; a progress report on grievances, ethics, and licensure entitled "Disciplining Ourselves"; and "A Taste of Practice Management" by Duane Johnson, executive vice president of Practice Productivity Inc.

The Officers' Conference will begin Wednesday, April 12 at 1:00 p.m. and will adjourn at noon on Thursday, April 13.

State Society membership at all time high

Membership in the State Society increased in 1977 to 14,657, or 440 more than in 1976.

A breakdown of the new figures shows an increase in active dues paying members of 161 and in intern/residents of 105, for a total of 266. The increase in these categories for 1976 was 431. Affiliate membership increased by 92 and associate by 148 in 1977. In all, 1,058 new members were processed for the year, the same number as were processed in 1976.

The counties noting the greatest increase in membership during 1977 are: Dauphin, 31; Cambria, 27; Allegheny, 26; Bucks, 19; Lehigh, 19; and Washington, 18. Because of their increase in membership, Bucks, Cambria, and Centre County Medical Societies each will gain one delegate to the State Society House of Delegates. The Luzerne County Medical Society will lose one delegate because of a drop in membership.

In contrast to the rise in State Society membership, American Medical Association membership in Pennsylvania for 1977 dropped by 300, or 3.2 percent. Five or more members were lost in 12 counties. With a total membership count of 9,170, the State Society maintains its tenth delegate to the AMA by an approximate margin of 160.

Those counties losing the largest number of AMA members are: Philadelphia, Montgomery, Allegheny, Delaware, Erie, and Berks.

At 113th Annual Dinner

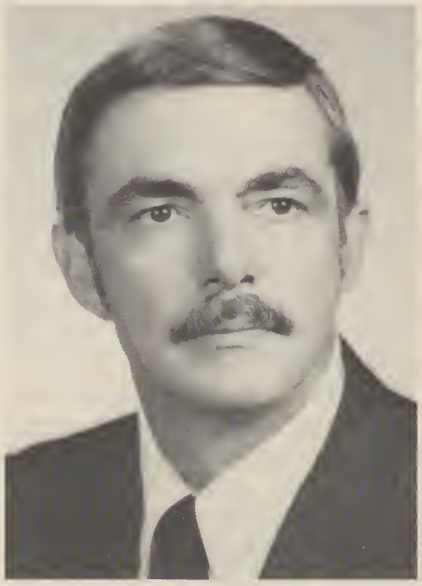
Allegheny County society honors three members

The 113th annual dinner of the Allegheny County Medical Society (ACMS) featured the presentation of awards to several society members.

David W. Clare, M.D., was named to receive the Ralph C. Wilde Award, one of the society's highest accolades. The Wilde Award, named in honor of the late ACMS president who served as State Society president in 1974, is given to "a physician who exemplifies the rare combination of qualities—as physician, teacher, leader and human being—which characterized Dr. Wilde."

Dr. Clare has been active in organized medicine since becoming an ACMS member in 1948. He is a member of the county society's board of directors and of the State Society's Board of Trustees and Councilors.

Dr. Clare is clinical associate professor of surgery and an active participant in continuing education programs at the University of Pittsburgh School of Medicine. He is a leader in American Cancer Society activities in the Pittsburgh area.



DR. LEVIS



DR. FRONCZEK

Also honored by his county society is Michael P. Levis, M.D., recipient of the Frederick M. Jacob Physician's Merit Award. The award recognizes outstanding service to county medicine through the Allegheny County Medical Society.

Dr. Levis is active at all levels of organized medicine. He is secretary of the National Board of Directors of the American Medical Political Action Committee and an American Medical Association delegate. He is past chairman of the State Society's Council on Governmental Relations and a PMS delegate. In addition, he is a member of the county society's board of directors and served as ACMS president in 1975.

The Nathaniel Bedford Award was presented to William M. Fronczek, Sr., M.D. The award honors a primary care physician for dedication over an extended time to his patients' physical and psychological needs.

Dr. Fronczek, a general practitioner, has practiced medicine in the Arsenal area for more than 40 years.



HONORED by his county medical society as recipient of the Ralph C. Wilde Award, David W. Clare, M.D., Tenth District trustee, testified in Harrisburg in January before the House of Representatives Committee on Health and Welfare. He presented the Society's position of opposition to the legalization of laetrile.

"Texas physicians report on a self-administered peritoneal dialysis system... Dr. Salk protests widespread news reports of imminent cure for multiple sclerosis... a survey of malpractice cases uncovers the most common causes of claims... Canadian cardiologists offer a technique for diagnosing angina caused by coronary-artery spasm... the IRS is clamping down on tax shelters but some programs still work... CT scanning is shown to detect hidden abdominal injuries resulting from auto accidents.."

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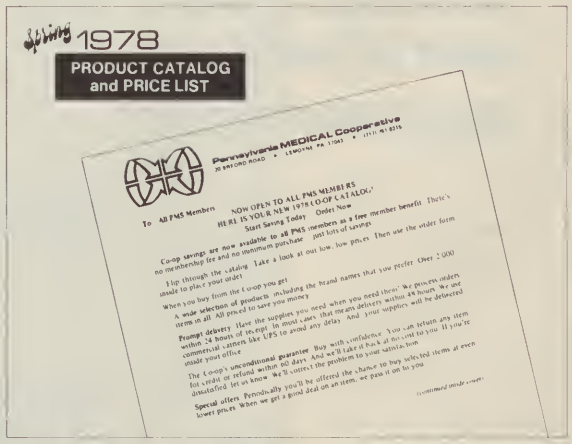
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Confident Clinical Office Management

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The University of Chicago/The Pritzker School of Medicine

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Rush-Presbyterian/St. Luke's Medical Center, Chicago, Illinois
ROBERT W. GIBSON, M.D.
Sheppard & Enoch Pratt Hospital, Towson, Maryland
LEO E. HOLLISTER, M.D.
Stanford University School of Medicine, Palo Alto, California
HEINZ E. LEHMANN, M.D.
McGill University Faculty of Medicine, Montreal, Canada
JOSEPH J. SCHILDKRAUT, M.D.
Harvard Medical School, Boston, Massachusetts
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Residents in action

Medical residents set goals under State Society auspices

Brenda Baumann, M.D.



OFFICERS of the Governing Council of the Resident Physicians Section of the Pennsylvania Medical Society met January 28 in Lemoyne, to plan 1978 activities. Shown above are Drs. Alan Sooho, Steven J. Davidson, Brenda Baumann, and Patrick Jonas. Dr. Jonas is RPS chairman.

Pennsylvania's resident physicians formally organized in 1977 and held their initial meeting in conjunction with the State Society's Annual Session of the House of Delegates. The Commonwealth is now one of the few states which has a functioning Resident Physician Section. The establishment of the section signifies that the Pennsylvania Medical Society sees the participation of young physicians as vital to the future of the profession.

The new Resident Physicians Section (RPS) is open to all resident physicians in the state who are PMS members. At the end of 1977 the State Society had 651 residents as duespaying members. The section is seen as an instrument for the exchange of information among residents and their senior colleagues in the State Society. It is also viewed as the vehicle by which the ideas and opinions of young physicians are influential in the Society's policy making process.

The State Society sought at the outset to have the new RPS involved in the activities of the AMA's Resident Physicians Section, which holds meetings twice yearly in conjunction with AMA's meetings and presents national position to the AMA.

Although the fledgling section had been organized for just a month, members of its governing council were sponsored to attend the AMA meeting in Chicago in December 1977 by their respective county medical societies, with one exception. RPS Chairman Patrick Jonas, M.D., a family practice resident at Hershey Medical Center, attended as a workshop leader whose expenses were provided by the AMA. Others who attended were: Brenda Baumann, M.D., a resident in family practice at Harrisburg Hospital, sponsored by the Dauphin County Medical Society; Steven J. Davidson, M.D., a resident in emergency medicine at the Medical College of Pennsylvania, Philadelphia, and Alan Sooho, M.D., a psychiatry resident at the Hospital of the University of Pennsylvania, sponsored by the Philadelphia County Medical Society; and Robert Snyder, M.D., internal medicine resident at Geisinger Medical Center, sponsored by the Montour County Medical Society. Also in attendance, and elected chairman of the AMA-RPS at that meeting was Patrick Tokarz, M.D., Hershey, who was active in organizing the PMS-RPS.

The AMA-RPS is promoting new essentials for graduate medical education. Being present at the December meeting provided invaluable insights to the officers of

Dr. Baumann is a second year resident in the department of family medicine at Harrisburg Hospital.

the new Pennsylvania group. Among the concepts studied and developed at the December meeting were physician well being, teaching skills for residents, and cost effectiveness in medical care.

Physician well being is a movement to find and rehabilitate behaviorally impaired physicians. The resident section is researching ways to prevent, in medical school and residency, those stresses which set the stage for alcoholism, drug addiction, depression, suicide, and bad marriages among physicians. The goal is to develop programs aimed at early recognition and prevention for use by future physicians during medical school and residency training.

A workshop on cost effectiveness at the December meeting was a forum for numerous ideas on how to expose residents and students to price conscious ordering practices. Little training in this area has been available in the past.

Teaching skills for residents were emphasized in a workshop where a consensus was reached that residents must develop such skills because physicians are teachers throughout their careers. A physician is a teacher of himself, his patients, and his colleagues. Improvement in teaching skills during residency is a goal of AMA-RPS.

The participation of resident physicians from the entire state is necessary to continue to develop PMS-RPS goals and to fulfill them. All interested residents are invited to contact the PMS-RPS by sending their names and addresses to Brenda Baumann, M.D., 707 Edison Rd., Dauphin, PA 17018. The governing council will respond to all inquiries.

The section needs input to develop programs and policy; it can provide information on PMS services available to residents; it makes the voice of young physicians strong and vital in the profession.

New editions of pediatric manuals available

New editions of two important manuals for physicians—on infectious disease and hospital care of newborns—have been issued by the American Academy of Pediatrics.

The new edition of the *Report of the Committee on Infectious Diseases,* commonly known as the *Red Book,* contains changes in recommendations for immunization against measles and poliomyelitis, and new sections on urinary tract infections, otitis media, rotaviruses, pneumococcal infections, opportunistic infections, and college health programs.

Included in the new edition of *Standards and Recommendations for Hospital Care of Newborn Infants,* developed by the AAP Committee on Fetus and Newborn, are guidelines for regionalization of perinatal care for mothers and infants.

Each manual is available for $6.00 per copy from the American Academy of Pediatrics, Department P, PO Box 1034, Evanston, IL 60204.

Pittsburgh neurosurgeon to address ethical issues at Officers' Conference

Donald H. Reigel, M.D., chief of pediatric neurosurgery at Children's Hospital in Pittsburgh, will address the Officers' Conference prayer breakfast at Hershey Motor Lodge on Thursday, April 13, at 7:30 a.m.

Dr. Reigel will outline what he believes to be the major ethical conflicts confronting the medical profession today. He believes the issues must be discussed, regardless of the position taken, in order to break down the barriers now surrounding medical ethics.

Dr. Reigel suggests that the following types of issues, drawn from his own specialty, should be discussed and evaluated:

- What should be done with information gathered from pregnancy screening? Should testing be compelled? If conditions warrant abortion, should it be mandated?
- How early is a child viable? If there are difficulties in the birth process, should the child be maintained artificially?
- When should a tube be inserted in a child who has been admitted to emergency with cardiac arrest?
- What impact does reconstruction of face and head have for children? Should it be carried out?
- Is the public responsible for financial maintenance of neonatal intensive care units when in practicality the patients will not make a contribution to society?

The prayer breakfast, a new addition to Officers' Conference this year, is sponsored by the Commission on Medicine, Religion, and Bioethics. The Commission's newly expanded role under the Council on Education and Science is to promote frequent and open discussion of medical ethics issues.

Pressure threatened to force immunization participation

State Health Secretary Leonard Bachman, M.D., has threatened to pressure officials in 17 school districts for failing to participate in a special measles immunization campaign for children begun by the Health Department in April 1977.

"Unless these 17 school districts can give us satisfactory answers for not participating in our measles campaign, and we are not satisfied with their responses thus far, I intend to look into means to bring them into compliance," Dr. Bachman said.

The school district responses ranged from "Don't think program is necessary," "Immunity levels already high enough," "District doctor and administration against program," and "School board would not allow program" to "Too expensive with extra bussing required," and "Don't care to participate."

The 17 school districts which have not participated are listed in the accompanying table.

A total of 3,686 cases of measles (rubeola) were reported in Pennsylvania in 1977 as compared with 3,682 cases in 1976. The incidence of measles in two years increased 500 percent from 1975 when 611 cases were reported.

School Districts Not Participating in Health Department Measles Immunization Program

County	*District*
Beaver	Midland Boro
	Western Beaver
Blair	Bellwood-Antis
Bucks	New Hope Solebury
Butler	Slippery Rock
Centre	Bellefonte
Clarion	Redbank Valley
Delaware	Chester Upland
	Haverford Township
	Marple Newtown
	Upper Darby
Lancaster	Ephrata
	Lampeter-Strasburg
Lebanon	Annville-Cleona
Lehigh	Northern Lehigh
Perry	Greenwood
	Newport

"For the past two years, the Health Department has been very concerned with a large increase in the number of measles cases in Pennsylvania, particularly in middle, junior, and senior high school students," Dr. Bachman said. "To date, the State Health Department has assisted districts in administering 226,682 doses of measles vaccine to students in 422 districts with an additional 13 districts expected to complete their programs in March."

Dr. Bachman anticipates that by March measles protection in each school district that conducted a program will be at the 92-95 percent immunization level, the highest in the state's history.

"There's no reason why Pennsylvania school children in every school district cannot be afforded this protection in this day and age," Dr. Bachman said.

Kenneth L. Cooper, M.D., of Williamsport, member of the State Society Board of Trustees, has been reappointed to a two-year term on the Pennsylvania Medical Cooperative Board of Directors. Representing the PMS Board with Dr. Cooper is David J. Keck, M.D., of Erie.

Licensing boards' turmoil continues

Fred Speaker, Esq.

Last month's PENNSYLVANIA MEDICINE indicated[1] that licensing boards were somewhat disabled because of an opinion[2] reversing a board's license suspension because the prosecutor also advised the board. A more recent opinion, just published,[3] once again says that there cannot be a mixture of prosecutorial and adjudication functions:

> An attorney providing prehearing legal advice to an adjudicatory body should not then serve as prosecuting attorney; the prosecutor should not assume a role of providing legal advice to the hearing body; and finally, the drafting and review of the final Adjudication and Order should be the responsibility of someone other than the prosecutor, particularly any amendments thereto. Taken together such procedures create a sufficient appearance of impropriety as to warrant a denial of due process.
>
> Although we are unconvinced any actual prejudice adhered to Appellant's case, such procedures are so susceptible to prejudice that a remand for a proper hearing is required in order to insure the integrity of the administrative process.[4]

We must continue to look to the Pennsylvania Supreme Court to resolve the conflict between administrative expediency and fairness.

1/ *"Licensing boards flounder in due process decision wake,"* Pennsylvania Medicine *24 (February 1978).*

2/ Commonwealth, Department of State v. Chairman, *377 A.2d 1022 (Commw. Ct. 1977).*

3/ Bruteyn v. Commonwealth of Pennsylvania, State Dental Council & Examining Board, *380 A.2d 497 (Commw. Ct. 1977).*

4/ Id. *at 502 (citations omitted).*

Legal counsel reports

Does immunity mean impunity?

Fred Speaker, Esq.

Physicians are a special class of citizens. They have many specific duties imposed on them by government, often with criminal penalties for failure to comply. They also have particular grants of immunity for complying.

Physicians are required under Pennsylvania law to make reports or keep records, such as reporting abortions performed,[1] births,[2] deaths,[3] communicable diseases,[4] premarital[5] and prenatal[6] syphilis, animal bites,[7] lead poisoning,[8] cancer,[9] and recording controlled substances dispensed.[10] Despite the general ethical rule that a "physician may not reveal the confidences entrusted to him in the course of medical attendance,"[11] many of the foregoing requirements are enforced by criminal penalties ranging from a $25 fine[12] to two years imprisonment with a $25,000 fine.[13]

The Child Protective Services Law, enacted in Pennsylvania in 1975, contains similar reporting requirements and penalties—and attempts a solution. Under that law, physicians:

> . . . in the course of their . . . practice of their profession come into contact with children shall report . . . when they have reason to believe, on the basis of their medical, professional or other training and experience, that a child coming before them in their professional or official capacity is an abused child.[14]

A willful failure by a physician to make such reports is punishable as a summary offense, or as a misdemeanor for repeated violations.[15]

However, because the Child Protective Services Law places this enforceable burden on physicians, it attempts to grant them immunity from any liability for compliance with the law.

Immunity

The concept of immunity from liability has been a feature of jurisprudence for many centuries.[16] Starting with the doctrine of sovereign immunity, which may have had its roots in Roman law,[17] it became fully established in England by the sixteenth century.[18] The doctrine of sovereign immunity—that a ruling government cannot be successfully sued without its consent—became a part of the law in the United States in the early days of the Republic.[19] The states have also adopted the doctrine, and it was adopted in Pennsylvania in 1788[20] and is currently the law.[21]

Mr. Speaker is a member of the law firm of Pepper, Hamilton & Scheetz, which serves as the Society's legal counsel.

Historically, however, the doctrine has been eroded, and even eliminated in some jurisdictions. In 1946 Congress waived the immunity of the United States from liability in tort cases.[22] Several states have followed this trend.[23] The Pennsylvania Supreme Court has repeatedly called for the legislature to end the doctrine;[24] but this call has thus far been ignored. The efforts for abolition continue, however. Eleven cases that could bring judicial abolition of sovereign immunity were argued before the Pennsylvania Supreme Court at the beginning of 1978.

Provisions for immunity in other aspects of the law already have been abolished in Pennsylvania. Governmental or municipal immunity—covering local government units and school districts—was eliminated in 1973.[25] Eight years before, the doctrine of charitable immunity—covering non-profit hospitals and declaring that they are not liable for torts—was abolished.[26]

Other kinds of immunity created by judicial decision persist. Intrafamily immunity from tort liability—husband immune from liability to his wife[27] and parents immune from liability to their child[28]—continues. The immunity of public officers, such as prosecutors[29] and judges,[30] for actions taken in performance of their official duties still exists. Many of the foregoing types of immunity have seen serious limitations on their scope and effect, and even the absolute immunity of judges is under severe attack in the United States Supreme Court this term.

Just as the concept of immunity in some phases of the law has been shrinking under judicial decisions, it has been increasing by legislative fiat in other areas particularly beneficial to physicians. In 1963 the Pennsylvania General Assembly joined the substantial majority of other states in providing that a physician who renders emergency care in good faith has no civil liability for ordinary negligence or malpractice.[31] In 1974, the Peer Review Protection Act was enacted, providing civil and criminal immunity for physicians who provide relevant and truthful information to a peer review organization or serve on such an organization with due care and without malice.[32] Thus far there have been no reported cases of action against physicians in either of the areas protected by these two statutes.

Under the Child Protective Services

1/ *35 P.S. § 6608.*
2/ *35 P.S. § 450.401.*
3/ *35 P.S. § 450.502.*
4/ *35 P.S. § 521.4(a).*
5/ *35 P.S. § 521.12.*
6/ *35 P.S. § 521.13.*
7/ *28 Pa. Code § 27.4(a).*
8/ *28 Pa. Code § 24.4(d).*
9/ *28 Pa. Code § 24.4(c).*
10/ *35 P.S. § 780-112.*
11/ *AMA, Principles of Medical Ethics, § 8 (1977).*
12/ *35 P.S. § 251.20*
13/ *35 P.S. § 780.112.*
14/ *11 P.S. § 2204.*
15/ *11 P.S. § 2212.*

16/ *See Prosser, Torts 996-7 (3rd ed. 1964).*
17/ *Parker, "The King Does No Wrong-Liability for Misadministration," 5 Vand. L. Rev. 167 (1952).*
18/ *See 3 Holdsworth, History of English Law 463-69 (5th ed. 1942).*
19/ Cohens v. Virginia, *19 U.S. 264 (1821).*
20/ Respublica v. Sparhawk, *1 Dallas 357 (1788).*
21/ *See, for example,* Brown v. Commonwealth, *453 Pa. 566 (1973).*
22/ *Federal Tort Claims Act, 28 U.S.C. §§ 1346, 1402, 1504, 2110, 2401, 2402, 2411, 2412, 2671-80.*
23/ *See* Zerby v. Department of Transportation, *346 A.2d 914, 916 (Pa. 1975) (dissenting opinion).*
24/ *See, e.g.,* Biello v. Pennsylvania Liquor Control Board, *454 Pa. 179, 186-7 (1973);* Brown v. Commonwealth, *453 Pa. 566, 572 (1973).*

25/ Ayala v. Philadelphia Board of Public Education, *453 Pa. 584 (1973).*
26/ Flagiello v. Pennsylvania Hospital, *417 Pa. 486 (1965).*
27/ *See* Daly v. Buterbaugh, *416 Pa. 523 (1964).*
28/ *See* Restifo v. McDonald, *426 Pa. 5 (1967).*
29/ Freach v. Commonwealth, *354 A.2d 908 (Pa. Commw. Ct. 1976).*
30/ *See* Turack v. Gindo, *464 F.2d 533 (3rd Cir. 1972).*
31/ *12 P.S. § 1641.*

Law, however, a physician already has been sued, with the resulting cost of legal fees and professional time devoted to attendance at the trial. The law provides that:

> Any person, hospital, institution, school, facility or agency participating in good faith in the making of a report or testifying in any proceeding arising out of an instance of suspected child abuse, the taking of photographs, or the removal or keeping of a child pursuant to section 8, shall have immunity from any liability, civil or criminal, that might otherwise result by reason of such actions.[33]

Despite the grant of immunity in the Child Protective Services Law, there are three serious uncertainties in the provision from the standpoint of physicians: (1) what is meant by the provision of immunity for actions taken "in good faith", (2) what is the effect of the presumption of good faith, and (3) can a physician be sued and suffer the costs of a legal defense and loss of time even though the physician's actions were clearly taken in good faith.

Immunity for good faith action

When Pennsylvania enacted a Good Samaritan Law, it provided immunity only when a physician acted in good faith and excepted from immunity any acts:

> . . . intentionally designed to harm or any grossly negligent acts or omissions which result in harm to the person receiving emergency care.[34]

The Legislature went on to define good faith partially, saying that:

> "Good faith" shall include, but is not limited to, a reasonable opinion that the immediacy of the situation is such that the rendering of care should not be postponed until the patient is hospitalized.[35]

One expert has considered the question of good faith and his conclusions remain uncertain:

> . . . such statutes do not prevent the physician from being sued for malpractice, as the lawyer bringing suit need merely allege that the offending physician did not act in good faith, one of the prerequisites for the immunity granted by the statute. Most of the Good Samaritan statutes do require that the physician act in good faith, using this or some other similar term.
>
> The term good faith is fraught with uncertainty. Does good faith mean that the physician can make the most careless or reckless error in judgment or treatment and still be immune to legal action as long as his intentions were well-meaning? Or does good faith mean that slight mistakes, or even ordinary errors or negligence will be forgiven, but that gross errors will not? At present, there is no answer to these questions and there have been no cases which have interpreted any of these statutes.[36]

The effect of the provision in the Child Protective Services Law that participation in good faith gives the participant immunity thus will remain uncertain until the courts start to consider that provision.

Effect of good faith presumption

The Child Protective Services Law establishes a presumption that a reporting physician has acted in good faith:

> For the purpose of any proceeding, civil or criminal, the good faith of any person required to report cases of child abuse pursuant to section 4 shall be presumed.[37]

If such a presumption were conclusive, it would add substantial reassurance to physicians who are required to report. If, on the other hand, this statutory presumption is rebuttable, it only has the effect of shifting the burden of proof to the other side in a trial.

The courts have exhibited some difficulty in clearly explaining and distinguishing between presumptions of fact and presumptions of law, and between conclusive and rebuttable presumptions.[38] But it seems clear that the presumption in the Child Protective Services Law will operate only to place the burden of proving the absence of good faith on the party opposing the physician.[39]

Can physician be sued anyway?

Despite the provision in the Child Protective Services Law that a physician "shall have immunity from any liability," it must be recognized that the physician can be forced to stand trial. Immunity does not mean that there was no damage; it means there can be no recovery for damages:

> The privilege avoids liability for tortious conduct only under particular circumstances, and because these circumstances make it just and reasonable that the liability shall not be imposed, and so go to defeat the existence of the tort itself. An immunity, on the other hand, avoids liability in tort under all circumstances, within the limits of the immunity itself; it is conferred, not because of the particular facts, but because of the status or position of the favored defendant; and it does not deny the tort, but the resulting liability.[40]

It was perhaps the basis of this principle that led Attorney General J. Shane Creamer to rule that it is ". . . our opinion that the immunity from liability of physicians under the Good Samaritan Act, can, in no way, bind the Courts to rule that physicians are immune from suit in an actual suit. . . ."[41]

Furthermore, even a casual examination of the law books will reveal hundreds of cases reported which involved suits against individuals who were in a category that had already been declared to be immune from liability. And all those defendants had to pay their own attorneys' fees and suffer loss of their time during trial.

Under the law, physicians are immune from suit—but not without the risk of cost to themselves. That risk of cost is potentially significant. It is part of the burden that must be assumed by physicians because of their special status in society and as a concomitant to their extraordinary professional role as healers of the ill.

32/ *63 P.S. § 425.*
33/ *11 P.S. § 2211.*
34/ *12 P.S. § 1641.*
35/ *12 P.S. § 1642.*
36/ *Chayet, "Legal Implications of Emergency Care" pp. 30-1 (1969).*
37/ *11 P.S. § 2211.*
38/ *See* Watkins v. Prudential Ins. Co., *315 Pa. 497 (1934), and the cases cited therein.*
39/ Cf. Hodge v. MeBee Co., Inc., *429 Pa. 585, 590-1 (1968).*
40/ Prosser, supra *at 996.*
41/ *Opinions of the Attorney General of Pennsylvania 17, 18 (1972).*

Society awards highest honor to gastroenterologist

Henry L. Bockus, M.D., of Philadelphia will receive the State Society's highest award, the Distinguished Service Award, at the state dinner during the 1978 Session of the House of Delegates.

The Board of Trustees approved the nomination of the internationally known gastroenterologist on January 25. The Distinguished Service Award Committee presented the nomination to the Board of Trustees. Committee members are: A. Reynolds Crane, M.D., chairman; David S. Masland, M.D.; and William J. Kelly, M.D.

Dr. Bockus, a leading authority on diseases of the gastrointestinal tract, has been instrumental in establishing gastroenterology as a subspecialty and in making it available throughout the world. He helped found the World Organization of Gastroenterologists in 1958 and now serves as honorary president of the Bockus International Society of Gastroenterology, a group made up of 325 specialists in 21 countries, all of whom have studied with Dr. Bockus.

Dr. Bockus is emeritus professor of medicine and gastroenterology at the University of Pennsylvania School of Medicine.

Nobel laureate Baruch Blumberg, M.D., Glenside, is the Society's nominee for the American Medical Association Sheen Award. Dr. Blumberg, director of clinical research at Fox Chase Cancer Center, won the Nobel Prize in 1976 for his studies of how viruses cause disease. The Society nominated him for the same award in 1977.

Pediatrics groups meet

The Pennsylvania and New Jersey chapters of the American Academy of Pediatrics will hold their combined spring meeting and seminar April 27-30 in Bermuda.

Featured speakers at the seminar will be J. Alex Haller, M.D., Johns Hopkins Hospital; Jerome O. Klein, M.D., professor of pediatrics, Boston University School of Medicine, and associate professor of pediatrics, Harvard Medical School; and George J. Peckham, M.D., assistant professor of pediatrics, University of Pennsylvania School of Medicine and Children's Hospital, Philadelphia.

Physicians who attend the seminar may apply for 13 hours of Category 1 credit.

Accommodations during the three-day meeting will be at the Castle Harbour Hotel in Bermuda. For more information contact Russell Puschak, M.D., Pennsylvania Chapter (215-821-4920), or Stanley Karp, M.D., New Jersey Chapter (609-234-0330).

Dauphin, Delaware societies install officers

Members of the Dauphin and Delaware County Medical Societies met recently to install officers for 1978.

Thomas Fletcher, M.D., of Camp Hill, vice president for medical affairs at Harrisburg Hospital, succeeded Bernard Margolis, M.D., on January 11 as president of the Dauphin County Medical Society.

Other new officers for 1978 are: Lewis Patterson, M.D., of Harrisburg, president elect; Patrick D. Forsythe, M.D., of Camp Hill, first vice president; John Burnside, M.D., of Hershey, second vice president; and David A. Smith, M.D., of New Cumberland, secretary-treasurer.

The Delaware County Medical Society installed its new president, W. William Nagle, M.D., of Media, on January 21. Dr. Nagle will head the 1978 slate of officers which includes: David J. McAleer, M.D., of Drexel Hill, president elect; John W. Lawrence, M.D., of Swarthmore, vice president; Wallace O. Lecher, M.D., of Media, secretary; and Samuel D. Allen, M.D., of Drexel Hill, treasurer.

Loan repayments to the educational fund of the Educational and Scientific Trust reached a new high of $86,160 in 1977, according to a recent report by the Trust. The total nearly matches the annual $8 assessment of PMS active membership dues allotted to the Trust.

Although the combined figure is substantially higher than in the past, the Trust is faced with the challenge of meeting ever increasing tuition costs: Hahnemann Medical College, for example, has projected for 1979 an increase in first year tuition from $6,100 to $10,000.

Seminar spotlights rural health needs

In response to the growing interest of health professionals in rural health care, the department of family and community medicine at the Pennsylvania State University School of Medicine in Hershey recently sponsored a two-day conference on "Innovations in Rural Health."

Plenary sessions and workshops at the March conference addressed both clinical and nonclinical aspects of health care in rural areas.

The meeting, organized by Thomas Leaman, M.D., chairman of the department at Hershey, featured a presentation by PRIMACARE vice president Robert Leipold, M.D., director of the department of family medicine at Geisinger Medical Center in Danville.

Justice Department to investigate medicare, medicaid

In response to what it believes is widespread fraud in Pennsylvania's $800 million-a-year medicaid and medicare programs, the state Justice Department has begun development of a new investigation and prosecution unit.

According to deputy state attorney general Peter Foster, the unit will investigate "the siphoning of perhaps 15 to 20 percent of the medical payments, or more than $100 million a year in possible illegal schemes."

Such schemes, he said, range from physicians' overcharging or billing for nonexistent services to kickbacks and nursing home fraud.

Foster had no estimate of how widespread fraud might be in the state, but he said there are now 170 "active cases," not including nursing homes, in the Welfare Department.

"Judging from efforts in other states and the scope of criminal activity elsewhere, we're assuming it's a serious problem in Pennsylvania," he said.

Foster said the state expects to receive $1.75 million a year in federal money under a law passed by Congress last fall. The legislation redefined most fraudulent acts in medicare and medicaid as felonies. Maximum penalties were increased from one year in prison and a $10,000 fine to five years' imprisonment and a $25,000 fine.

Although the U.S. Department of Health, Education, and Welfare has been moving to expand its own investigative functions, Foster said Congress believes state agencies are closer to specific patterns of fraud. "For criminal investigations in this area, you need close contact and information from the state welfare agency which pays all these providers. What we are seeking to uncover are patterns of fraud.

"But that doesn't mean the U.S. attorneys will be out of the picture. In some cases, federal law will be more applicable."

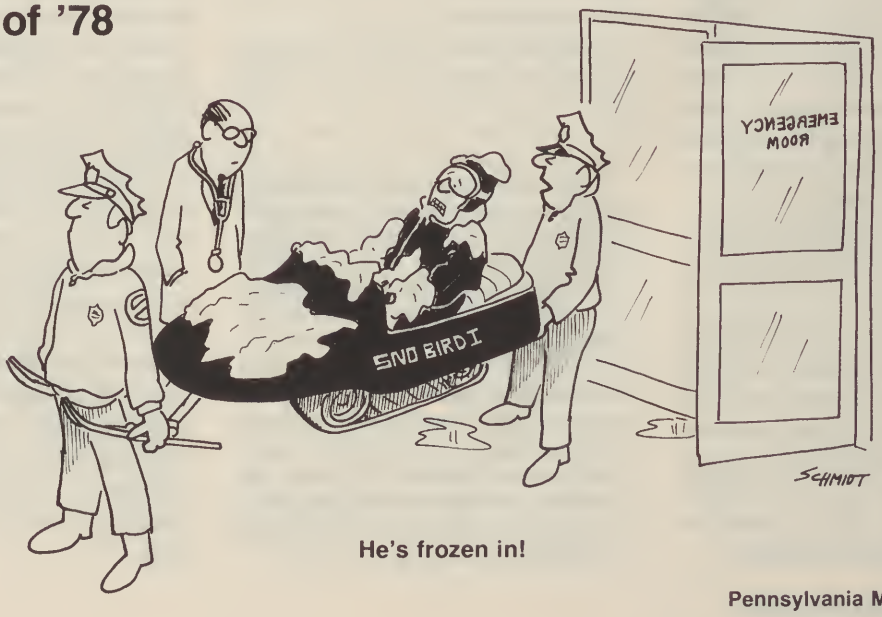
Pitt scientists develop new vaccines

Research scientists at the University of Pittsburgh have announced the development of vaccines against three major bacterial diseases and advances toward the development of vaccines using bacterial pili to control some bacterial diseases.

Under the direction of Dr. Charles Brinton, professor of microbiology, the team has developed the following vaccines: a *Neisseria gonorrhoeae* pilus vaccine, evaluated in a small number of human volunteers; an *Escherichia coli* pilus vaccine (diarrhea, including fatal infantile strains and common travelers' discomfort), evaluated in newborn piglets; and a *Pseudomonas aeruginosa* pilus vaccine (an especially virulent disease found in burn cases and in postoperative septicemia), evaluated in experimentally burned mice.

Brinton's team, which was cited in 1977 by the American Medical Association for developments in the field of gonorrhea research, also is undertaking research on other bacteria-caused diseases, among them meningitis, cholera, urinary tract infections, conjunctivitis, and salmonella.

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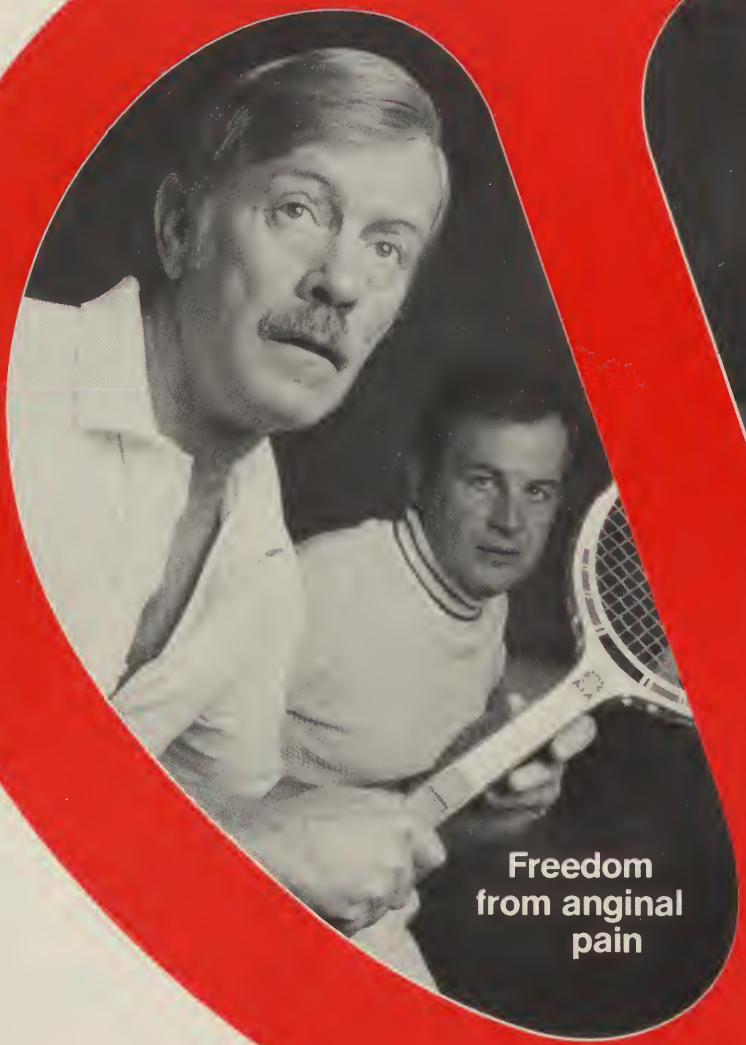
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Continued on page 26.

Office counseling

Medical-legal aspects of the doctor-patient relationship

Robert L. Sadoff, M.D.

The doctor-patient relationship is central to the practice of medicine. The doctor has a duty to his patient and must vigilantly guard his obligations and responsibilities. The elements of this duty include the following:

- He owes due care and skill
- He must not abandon his patient
- He must be available in time of need or crisis, or provide a competent substitute
- He must be honest with his patient
- He must provide the patient with proper information on which to base a valid consent for treatment
- He must maintain the privacy of his patient's medical and personal conditions

Certain aspects of the doctor-patient relationship have evolved as ethical standards or have been established by law. In many instances, the law has been helpful in redefining therapeutic goals and aiding in the care and treatment of patients. In other instances, the law has perhaps gone beyond the point of therapeutic benefit to patients in the interest of preserving individual civil rights, despite the fact that certain patients may suffer physical or emotional harm as a result.

Familiarity with current ethical and legal considerations of medical practice can help physicians build strong doctor-patient relationships and avoid malpractice difficulties stemming from breach of duty to the patient.

This article will consider several aspects of the doctor-patient relationship which are of major medical-legal importance.

Confidentiality

The American Medical Association has developed ethical guidelines and standards for physicians on the matter of confidentiality: "A physician may not reveal the confidences entrusted to him in the course of medical atten-

dance or the deficiencies he may observe in the character of patients, unless he is required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or of the community."

Based on this original ethical standard, psychiatrists have added modifications which relate to the "dangerousness" of the patient. If a patient is suicidal or homicidal or is "an imminent danger," the psychiatrist may reveal the confidential information disclosed by the patient in order to protect the welfare of the patient or the community. This special consideration holds true for all physicians who deal with potentially violent or suicidal patients who require hospitalization or immediate treatment.

Privileged communications

The law has established that privileged communications belong to the patient. Generally, the privilege restricts the physician from testifying on matters that occur in the doctor-patient relationship or in the care and treatment of the patient.

Exceptions to the privilege rule are so broad, however, that they almost nullify the restrictions of the privilege. For example, the privilege does not apply in Pennsylvania in any criminal case. If the patient has engaged in criminal behavior, the physician's records may be subpoenaed and the physician may be required to testify regarding relevant medical information. The patient is considered to have waived his privilege automatically by becoming involved in criminal behavior. When the physician is requested to evaluate a patient for legal purposes, the privilege also does not apply. Finally, the patient is said to have waived his privilege if he raises a medical issue at a personal injury or other civil trial in order to obtain an award from the court. The award may be a judgment in his favor, a financial settlement, custody of his children, or his freedom from hospitalization. When the patient submits his physical or mental health as an issue, he waives his privilege and the physician may testify.

Privacy of medical records

The relatively recent problem of privacy of medical records has emerged since activation of the Freedom of Information Act of 1972 and the privacy amendment of 1974. As a result, physician's records, especially in federal hospitals, have been available to patients upon request. Many problems have arisen in cases in which patients have sought to review their records of psychiatric hospitalization and have been successful in obtaining them.

In general medical practice, similar, though perhaps less sensitive, problems may arise. It may be detrimental for the patient to confirm a diagnosis or a medical condition by reading about it in his chart before properly discussing the matter with the physician. Formal guidelines should be established for patients who wish to review their records: the patient should review his records in a designated area of the hospital when a physician is present to help interpret the information and to assist the patient in understanding the implications of what is written in the records.

When the physician is aware that a chart may be reviewed by the patient, he is sensitive to what he wants his patient to read. Certainly vital data should be as complete as possible. The physician should confine comments, however, to non-damaging and non-intimate statements.

Patient records may also be reviewed by various outside agencies, including third party payers, insurance companies, courts, hospital utilization review committees, PSRO review boards, and several other legitimate and authorized groups, individuals, or agencies. As a result, the confidentiality of the doctor-patient relationship has been eroded extensively. Total secrecy, as initially conceived, is no longer possible. Thus judgment and discrimination play a vital role in the recording of medical data.

Dr. Sadoff is clinical associate professor of psychiatry at the University of Pennsylvania School of Medicine and lecturer in law at the Villanova University School of Law.

Patient's rights

A number of recent changes in the law stemming from national cases and state legislation have affected the practice of psychiatry particularly, but also the practice of medicine in general. Examples of these are the so-called "right to treatment" and "right to refuse treatment" cases, which generally fall under the rubric of patients' rights.

Involuntary hospitalization for extended periods for individuals who are not in need of such care, and inappropriate or excessively restrictive treatment of those who are so confined, has been seen by civil rights attorneys and others as abuse by physicians, particularly psychiatrists. The law has addressed these issues at various levels: it has redefined and limited the criteria for involuntary hospitalization; redefined the meaning of "treatment" in the hospital; and established various rights for patients, including the right to have a lawyer, the right to privacy, the right to be free from treatment as punishment, and the right to be free from excessive treatment or "dangerous" treatment, such as psychosurgery or electroshock therapy or other forms of behavior modification which may cause damage to patients.

The right to treatment cases also have established, through constitutional and legislative authority, the right of an involuntarily confined patient to have adequate treatment rather than being assigned to custody or "milieu therapy."

The right to treatment issue should not be misinterpreted to read that treatment is mandated against the patient's will, for a number of cases have established that patients also have a right to refuse treatment. It is on this issue that the ongoing tension between lawyers and physicians is based. The doctor will maintain that if the patient is hospitalized, he is obviously there for treatment; it is assumed that the physician is best qualified to select the proper treatment and should be given the authority to do so without legal interference. The courts have disagreed, however, and have established the guideline that the patient has a right to refuse treatment unless: (1) the lack of treatment (usually the discontinuing of medication) will result in the patient becoming violent to himself or to others, (2) there is an immediate crisis, or (3) the patient is not competent to refuse treatment.

Informed consent

The doctor-patient relationship is extremely important in helping the patient to accept recommended and prescribed treatment. Lack of trust or difficulty in establishing a proper physician-patient relationship may result in the patient's refusal of treatment.

The issue of informed consent to treatment has become increasingly important in the practice of medicine. In any surgical procedure, for example, the surgeon is required to inform the patient of results he can expect, side effects that may occur, and anticipated consequences of the procedure. In most instances the patient is relatively competent to understand the information given him by the physician and to decide whether to proceed with the operation. If he consents, he often signs a form indicating that he has been told by the physician what to expect. The implication is that he does not hold the physician responsible for untoward reactions if the physician is not negligent in his skill and care.

When there is a question about the patient's competency to give consent or to understand the information given him, a psychiatrist may be called as a consultant to determine whether the patient is competent to make an informed decision. If the psychiatrist believes the patient is incompetent, he informs the surgeon. The family may then give permission for a necessary procedure, especially if the operation is required on an emergency basis. When there is no emergency, the problem should be heard by a judge who may determine the patient's competency and, if necessary, appoint a guardian to consent to the procedure.

If a person is admitted to the emergency room in coma and requiring emergency care when family members are not present, the doctor may proceed with his customary skill to do all he can to preserve the life and health of the patient under the doctrine of implied consent. The law assumes that a reasonable man, if he were able at the time of his entry into the emergency room, would consent to the emergency procedures offered.

In obtaining informed consent, it is always recommended that a careful record be made of the physician's explanation and the patient's response

new members

Continued from page 23.

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Continued on page 54.

in the event the patient does not recall the preoperative discussion and claims that he was not told about possible side effects or consequences of various procedures.

Inappropriate relationships

An important consideration of the doctor-patient relationship stems from the "Do no harm" phrase of the Hippocratic Oath. A number of malpractice suits have originated from harm resulting from inappropriate doctor-patient relationships. This inappropriateness may occur in two areas: (1) That which is called inappropriate touching, or assault and battery. These cases occur when patients are treated against their will, or without proper informed consent are given injections or other physical treatments which they claim have caused harm. The damage may be physical, psychological, or economic; and (2) The delicate matter of sexual relations between physician and patient. By all ethical standards, sexual relations between doctor and patient are forbidden and may lead to serious harm to the patient. A number of physicians have been sued for such indiscretions based on the claim that the patient was emotionally disturbed following the cessation of intimate relations and blamed emotional or marital problems on the sexual relationship with the physician. It behooves the physician who becomes emotionally involved with a patient to stop making medical decisions about that patient's care. He is no longer in a position of professional neutrality, and errors in judgment may ensue.

The doctor-patient relationship is regulated by law. Every practicing physician must be aware of his duty to his patients and the regulations imposed upon him, while constantly maintaining the highest ethical standards. He must observe confidentiality in the course of his practice. He must know when he may not testify about a patient he has treated. He must know how to inform a patient in order to obtain a proper consent for treatment. He must know the limits of his professional skills. Finally, he must remain alert to changes in law which regulate his practice and maintain an interest in legislation that affects physicians and their patients. □



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*R. B. Greenblatt, M.D.; R. Witherington, M.D.,; I. B. Sipahioglu, M.D.; Hormones for Improved Sexuality in the Male and Female Climacteric. **Drug Therapy,** Sept. 1976.

DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE: Robert B. Greenblatt, M.D.,** and **D. H. Perez, M.D.:** "The Menopausal Syndrome," *Problems of Libido in the Elderly*, pp. 95-101. Medcom Press, N.Y., 1974. HOW SUPPLIED: 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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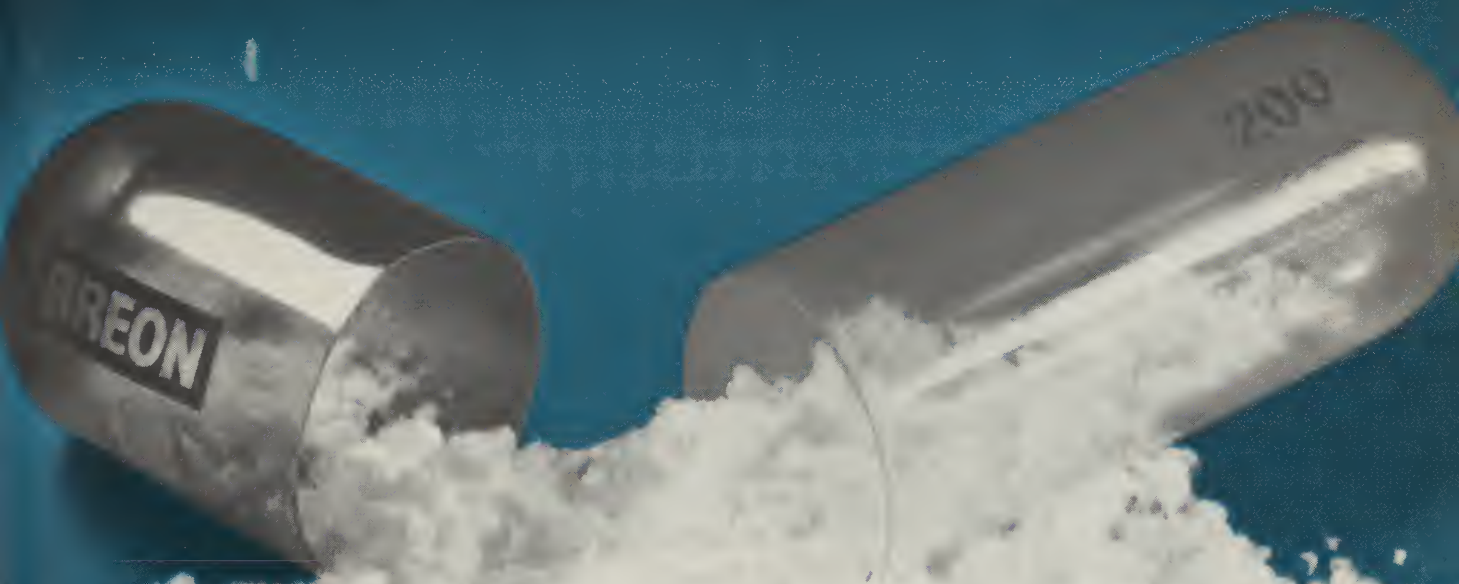
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WARNINGS: All methylxanthines should be used with caution in children and in others who are currently taking bronchodilator products, especially in rectal dosage form, which may contain theophylline or related drugs.

USAGE IN PREGNANCY: Although theophylline has been used for many years, with no evidence of adverse fetal effect or teratogenicity, its safety in pregnancy has not been established. Therefore use of Bronkodyl during lactation or in women of childbearing potential requires that possible benefits of the drug be weighed against possible hazards to fetus or child.

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Contraindications: Severe renal impairment with oliguria or azotemia, untreated Addison's disease, adynamia episodica hereditaria, acute dehydration, heat cramps and hyperkalemia from any cause.
Warning: There have been several reports, published and unpublished, concerning nonspecific small-bowel lesions consisting of stenosis, with or without ulceration, associated with the administration of enteric-coated potassium tablets alone or when they are used with nonenteric-coated thiazides or certain other oral diuretics. These small-bowel lesions have caused obstruction, hemorrhage and perforation. Surgery was frequently required and deaths have occurred. Available information tends to implicate enteric-coated potassium salts, although lesions of this type also occur spontaneously. Therefore, coated potassium-containing formulations should be administered only when indicated and should be discontinued immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur. Coated potassium tablets should be used only when adequate dietary supplementation is not practical.
Precautions: In response to a rise in the concentration of body potassium, renal excretion of the ion is increased. With normal kidney function, it is difficult, therefore, to produce potassium intoxication by oral administration. However, potassium supplements must be administered with caution, since the amount of the deficiency or daily dosage is not accurately known. Frequent checks of the clinical status of the patient, and periodic ECG and/or serum potassium levels should be made. High serum concentra-

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tions of potassium ion may cause death through cardiac depression, arrhythmias or arrest. This drug should be used with caution in the presence of cardiac disease.

In hypokalemic states, especially in patients on a salt-free diet, hypochloremic alkalosis is a possibility that may require chloride as well as potassium supplementation. In these circumstances, Kaon (potassium gluconate) should be supplemented with chloride. Ammonium chloride is an excellent source of chloride ion (18.7 mEq. per Gram), but it should not be used in patients with hepatic cirrhosis where ammonium salts are contraindicated. Other sources for chloride are sodium chloride and Diluted Hydrochloric Acid, U.S.P.

It should also be kept in mind that ammonium cycle cation exchange resin, sometimes used to treat hyperkalemia, should not be administered to patients with hepatic cirrhosis.

Adverse Reactions: Nausea, vomiting, diarrhea and abdominal discomfort have been reported. The symptoms and signs of potassium intoxication include paresthesias of the extremities, flaccid paralysis, listlessness, mental confusion, weakness and heaviness of the legs, fall in blood pressure, cardiac arrhythmias and heart block. Hyperkalemia may exhibit the following electrocardiographic abnormalities: disappearance of the P wave, widening and slurring of QRS complex, changes of the S-T segment, tall peaked T waves, etc.

Overdosage: Potassium intoxication may result from overdosage of potassium or from therapeutic dosage in conditions stated under "Contraindications." Hyperkalemia, when detected, must be treated immediately because lethal levels can be reached in a few hours.

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Precautions: See Kaon Tablets.

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Adverse Reactions: See Kaon Tablets.

Overdosage: See Kaon Tablets.

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State Pathologists test quality control

Day to day precision in clinical chemistry laboratories

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Thomas D. Moses, B.S., M.T.
Howard J. Berman, M.D.
William V. Dorwart, Jr., Ph.D.

In the past few decades, it has become standard practice for clinical laboratories to evaluate their day-to-day analytic precision by analyzing control material concurrently with patient specimens. Values obtained by these control analyses are used to calculate means and standard deviations (SD), creating limits to which future control values are compared.

When a group of analyzed patient specimens is accompanied by a control value outside of established limits, the method is considered "out of control." Patient results may not be released until the cause of the deviance from expected values is corrected and the patient and control specimens reassayed.

In addition, the mean and SD of the control values are recalculated and evaluated at intervals for possible change from preceding levels. This approach to process quality control is now mandated by professional societies and governmental agencies with jurisdiction over clinical laboratories.

Many laboratories have joined regional quality control programs since 1967.[1] In these programs, all participant laboratories use the same quality control materials and data processing service and share information from control analyses. This is used to calculate mean and precision information for groups using similar methods.

Some objectives of the regional approach are to:

- Allow use of control material that has not been assayed by the manufacturer, providing instead multiple analyses by participants and thus reducing costs;
- Further reduce costs by use of joint purchasing power;
- Provide inexpensive automatic processing of the individual laboratory's data, with storage and recalculation over the period of the program;
- Provide legible quality control records, including wall charts and corrective action logs, for use by the laboratory and by accrediting and licensing bodies;
- Provide a data base to demonstrate state-of-the-art laboratory performance associated with differing constituents, methods, and instruments; and
- Advance the state-of-the-art by providing peer performance information as a challenge for improvement.

Some regional programs are administered solely by manufacturers of control material; others are sponsored by professional societies. When the latter appoint active steering committees, further objectives are to:

- Advance the state-of-the-art of manufacture of control materials and data processing by working closely with a manufacturer;
- Assist with problem solving in participant laboratories through expert consultation;
- Represent the interests of the participants if problems arise with the manufacturer; and
- Disseminate information obtained from the program to the medical community.

Dr. DiSilvio is associate professor of pathology at Thomas Jefferson University in Philadelphia. Dr. Sax is associated with the department of pathology at the Western Pennsylvania Hospital, Pittsburgh. Mr. Moses is administrator of the Clinical Pathology Facility in Pittsburgh. Dr. Berman is associated with the Jeannete Pathologists. Dr. Dorwart is associated with the pathology laboratories at Bryn Mawr Hospital and the Hospital of the University of Pennsylvania. *The authors wish to thank the participant laboratories, whose willingness to share their data has made this assessment of precision possible, and the staffs of Laboratory Supply Corporation and Hyland Laboratories, who have contributed so much to the development and administration of this program.*

In keeping with the last objective, this paper presents precision information for selected serum chemical constituents and enzymes. The information has been obtained from data submitted by participants in the program sponsored by the Pennsylvania Association of Clinical Pathologists for the period of April 1976 through June 1977. Values from the PACP program are compared with those published in an independent survey of 61 tertiary care referral hospitals, described as "university or university-equivalent."[2]

Knowledge of the level of laboratory precision is important to the clinician as well as to the laboratory director. The practicing physician with knowledge of the analytic precision of his patients' results can judge more correctly the likelihood of abnormality of a borderline value, or of true physiologic change when two results apparently differ. From the viewpoint of the physician, who makes most decisions based on individual observations from a single laboratory, the day-to-day standard deviation of individual measurements within a laboratory would seem to be the most appropriate measure of analytic precision. This approach,[2] has been used in our report.

Data collection

Since 1971 the PACP has sponsored a regional quality control program in clinical chemistry. An early version of the program has been published,[3] but revision of the data processing has occurred since that time. Lyophilized human serum, at two levels, and data processing support are provided by a manufacturer (Hyland Laboratories,

Table 1. Comparison of Day-to-Day Precision Values of Constituents from the PACP Quality Control Program (1976-1977) and from the University and University-Equivalent Hospitals Study[2]

Chemical compound	PACP mean	Comparison range	Method	PACP 1SD	Comparison 1SD	Difference[a]	Comparison "most common" 1SD range	No. of comparison labs	No. of PACP labs	PACP labs in "most common" range (%)
Albumin, g/l	3.2	2.2-3.2	12/60 All	0.11	0.10	ND	0.06-0.11	27	66	62
	3.2		12/60 HABA	0.10	0.11	ND			13	
	3.2		12/60 BCG	0.11	0.13	ND			53	
	3.0		Electrophoresis	0.16	0.16	ND			39	
	3.2		All	0.13					230	
	4.1	3.3-5.0	12/60 All	0.12	0.12	ND	0.06-0.17	44	66	84
	4.2		12/60 HABA	0.12	0.11	ND			13	
	4.1		12/60 BCG	0.12	0.15	ND			53	
	3.9		Electrophoresis	0.21	0.18	ND			39	
	4.1		All	0.14					229	
Bilirubin, total, mg/dl	1.7	0.2-2.8	12/60	0.08	0.08	ND	0.03-0.09	30	70	86
	1.7		Manual, AA Evelyn-Malloy	0.13	0.11	ND	0.06-0.11	10	60	23
	1.7		All	0.11					282	
	4.2	3.0-7.8	12/60	0.15	0.17	ND	0.07-0.23	34	70	94
	4.2		Manual, AA Evelyn-Malloy	0.22	0.22	ND	0.19-0.28	18	61	88
	4.2		All	0.20					290	
Calcium, mg/dl	8.9	7.9-10.9	12/60	0.18	0.16	ND	0.06-0.19	38	70	66
	9.2		Atomic Absorbtion	0.22	0.22	ND	0.10-0.28	19	13	85
	9.0		All	0.22					255	
	12.1	11.0-14.0	12/60	0.20	0.20	ND	0.06-0.23	25	70	72
	12.0		Atomic Absorbtion	0.29	0.27	ND	0.19-0.28	12	13	45
	12.0		All	0.26					255	
Chloride, mEq/l	94.9	80-105	6/60	1.2	1.3	ND	0.6-1.6	45	45	93
	93.6		Chloridometer	1.7	1.6	ND	1.0-1.8	16	82	66
	94.5		All	1.6					272	
	112.8	106-125	6/60	1.3	1.4	ND	0.6-1.8	35	44	89
	112.2		Chloridometer	1.9	1.8	ND	1.1-2.0	13	82	53
	113.0		All	1.8					273	
Cholesterol, mg/dl	146	75-155	12/60	5.7	5.3	ND	2.9-7.0	16	48	75
	141		$FeCl_3$-H_2SO_4 extraction	6.4	6.4	ND	3.4-8.8	15	9	67
	143		All	5.9					252	
	192	159-260	12/60	6.7	6.8	ND	3.0-7.5	34	48	67
	178		$FeCl_3$-H_2SO_4 extraction	7.7	6.5	ND	3.9-7.6	15	9	67
	189		All	6.9					252	
CO_2, mM/l	9.9	6.6-15.8	6/60	0.92	0.99	ND	0.24-1.00	36	26	65
	11.0		All	1.09					89	
	27.4	16.0-38.0	6/60	1.41	1.12	ND	0.32-1.20	21	30	77
	26.9		All	1.50					104	
Creatinine, mg/dl	1.6	0.9-1.8	12/60, ACA	0.08	0.07	ND	0.04-0.11	37	83	96
	1.6		Manual, AA-alkaline picrate	0.11	0.10	ND	0.06-0.11	10	92	66
	1.6		All	0.10					248	
	5.0	1.9-7.3	12/60, ACA	0.10	0.10	ND	0.06-0.13	37	83	92
	4.9		Manual, AA-alkaline picrate	0.22	0.17	ND	0.12-0.18	8	92	56
	5.0		All	0.17					248	
Glucose, mg/dl	97.8	55-110	12/60-neocuproine	2.81	3.17	ND		28	33	83
	89.1		Hexokinase	2.94	3.00	ND		10	84	86
	88.9		AA-ferricyanide	3.55	3.46	ND		17	11	73
	88.7		Oxidase	2.95	3.18	ND		13	162	86
	89.2		AA-o-toluidine	3.03	3.03	ND		9	7	86
	90.0		All	3.03			1.0-4.0	77	362	85
	188.8	113-330	12/60-neocuproine	3.71	5.03	ND		31	33	90
	173.9		Hexokinase	4.19	5.35	ND		8	83	94
	178.2		AA-ferricyanide	4.81	5.41	ND		19	11	100
	174.3		Oxidase	4.51	6.44	ND		12	162	96
	174.2		AA-o-toluidine	8.76	5.39	D>		11	7	86
	175.9		All	4.62			5.0-8.0	81	362	91
Iron, μg/dl	76.0	50-110	All	6.4	5.4	ND	2.4-6.8	28	145	70
	181.3	114-227	All	9.0	8.3	ND	2.3-11.0	21	144	67

Iron binding capacity, μg/dl	278.3	178-300	All	17.9	16.4	ND	10.0-25.0	16	99	87
	342.6	303-489	All	21.4	20.1	ND	8.2-25.0	29	98	77
Lithium, mEq/l	0.8	0.3-1.0	Atomic absorbtion	0.08	0.04	D>	0.01-0.05	15	16	75
	0.8		Manual flame-IL	0.04	0.06	D<	0.01-0.05	15	29	83
	0.8		All	0.05					67	
	1.9	1.4-2.0	Atomic absorbtion	0.08	0.06	ND	0.01-0.10	15	16	88
	1.9		Manual flame-IL	0.07	0.08	ND	0.01-0.10	15	30	87
	1.9		All	0.08					68	
Magnesium, mEq/l	1.4	1.3-1.9	Atomic absorbtion	0.08	0.06	ND	0.03-0.08	13	22	68
	1.3		Manual	0.17	0.16	ND	0.12-0.19	9	42	71
	1.4		All	0.13					79	
	2.8	2.0-5.5	Atomic absorbtion	0.14	0.11	ND	0.04-0.14	12	22	73
	2.6		Manual	0.22	0.19	ND	0.12-0.20	11	40	48
	2.8		All	0.17					82	
Phosphorus, mg/dl	3.3	2.5-5.9	12/60	0.09	0.12	ND	0.05-0.13	35	63	79
	3.3		Manual, AA	0.18	0.14	ND	0.09-0.18	19	80	64
	3.3		All	0.13					206	
	7.2	6.1-8.8	12/60	0.17	0.18	ND	0.05-0.20	27	63	70
	7.3		Manual, AA	0.32	0.24	ND	0.16-0.25	11	70	41
	7.3		All	0.23					206	
Potassium, mEq/l	3.6	3.0-4.9	Automated flame	0.07	0.07	ND	0.04-0.12	34	53	92
	3.6		Manual flame-IL	0.08	0.08	ND	0.04-0.12	30	124	94
	3.6		All	0.08					254	
	6.2	5.0-8.0	Automated flame	0.10	0.10	ND	0.02-0.13	28	53	89
	6.2		Manual flame-IL	0.11	0.10	ND	0.06-0.13	27	124	85
	6.2		All	0.11					254	
Sodium, mEq/l	125.1	121-132	Automated flame	1.5	1.3	ND	0.6-1.7	21	54	78
	126.1		Manual flame-IL	1.4	1.6	ND	0.9-1.9	22	120	77
	125.6		All	1.5					257	
	150.6	133-160	Automated flame	1.5	1.4	ND	0.7-1.5	39	52	54
	151.0		Manual flame-IL	1.7	1.6	ND	1.0-1.9	35	119	71
	150.9		All	1.6					254	
Total protein, g/dl	5.2	3.3-5.4	12/60	0.11	0.10	ND	0.06-0.13	25	71	86
	5.0		Manual biuret	0.19	0.13	ND		5	29	
	5.1		All	0.12					194	
	6.6	5.5-8.0	12/60	0.12	0.12	ND	0.07-0.14	36	71	79
	6.6		Manual biuret	0.22	0.24	ND		7	29	
	6.7		All	0.14					195	
	4.8	4.7-7.3	Refractometer	0.09	0.08	ND		10	38	
	6.9		Refractometer	0.09	0.08	ND		10	40	
Triglycerides, mg/dl	61.9	43-126	Fluorometric	7.2	7.9	ND		13	7	
	80.9		Enzymatic	5.7	7.3	ND		14	72	
	72.1		All	5.7	7.7	ND	4.0-10.0	30	154	90
	73.4		Fluorometric	6.6	7.9	ND		13	6	
	100.0		Enzymatic	5.9	7.3	ND		14	68	
	89.1		All	6.1	7.7	ND	4.0-10.0	30	153	84
Urea nitrogen, mg/dl	21.9	12.0-26.8	6/60, 12/60 (PACP)	0.6	0.6	ND	0.3-1.0	45	87	100
	21.4		Urease	1.2	1.1	ND		6	107	
	21.8		AA, Diacetyl monoxime	0.7	0.7	ND	1.5-1.8	17	35	69
	21.7		All	0.9					277	
	45.0	35.0-85.0	6/60-12/60 (PACP)	0.7	1.0	ND	0.5-1.3	34	87	97
	44.5		Urease	1.8	2.1	ND		7	106	
	45.1		AA, Diacetyl monoxime	1.2	1.4	ND	1.0-1.6	11	35	80
	44.7		All	1.4					273	
Uric acid, mg/dl	4.8	3.5-7.0	12/60, ACA	0.12	0.11	ND	0.06-0.16	32	105	74
	4.5		Manual, AA-phosphotungstate	0.21	0.16	ND	0.04-0.20	17	70	61
	4.7		All	0.17					241	
	9.9	7.7-19.1	12/60, ACA	0.18	0.14	ND	0.07-0.20	25	105	63
	9.6		Manual, AA-phosphotungstate	0.35	0.24	ND	0.13-0.30	11	70	56
	9.8		All	0.26					239	

[a]Difference: ND = not different, $\frac{\text{SD larger}}{\text{SD smaller}}$ = less than 1.5

D> = different, $\frac{\text{SD larger}}{\text{SD smaller}}$ = 1.5 or more and SD PACP larger than SD comparison

D< = different, $\frac{\text{SD larger}}{\text{SD smaller}}$ = 1.5 or more, and SD PACP smaller than SD comparison

"Most common" range = range from comparison study[2] that includes at least 75 percent of those individual laboratory SD values.

HABA = hydroxyaminobenzoic acid albumin method, Technicon
BCG = bromcresol green albumin method, Technicon
12/60 = standard SMA 12/60 method, Technicon
6/60 = standard SMA 6/60 method, Technicon
AA = single and dual channel AutoAnalyzers I and II, Technicon
ACA = Automatic Clinical Analyzer, Dupont
IL = Instrumentation Laboratories

Table 2. Comparison of Day-to-Day Precision Values of Enzymes from the PACP Quality Control Program (1976-1977) and from the University and University-Equivalent Hospitals Study[2]

Enzyme	PACP mean	Comparison range	Method	PACP 1RSD	Comparison 1RSD	Difference*	Comparison "most common" RSD range	No. of comparison labs	No. of PACP labs	PACP labs in "most common" range (%)
Acid Phosphatase	9.0	no comparable pools	All	17.1					109	
Alkaline phosphatase	48.6	30-119	12/60	5.2	5.7	ND	2.3-9.0	41	71	94
	27.8		Other	9.6	6.7	ND	3.7-9.2	15	171	73
	39.8		All	6.5					242	
	192.8	120-300	12/60	3.1	5.2	ND	1.6-7.1	35	71	100
	123.5		Other	5.4	5.9	ND	1.1-8.0	9	167	87
	165.3		All	4.0					238	
Amylase	246.3	70-297	Amyloclastic	7.9	9.4	ND	4.6-13.1	40	188	94
	340.0	303-859	Amyloclastic	7.9	7.3	ND	2.2-10.9	21	187	91
Creatine kinase	70.4	71-97	Kinetic, UV	9.4	12.9	ND	6.9-16.1	13	148	95
	80.4		All	9.2					167	
	331.3	100-470	Kinetic, UV	6.6	9.9	D<	3.4-12.8	26	143	92
	343.8		All	6.9					165	
Glutamic oxalacetic transaminase (Aspartate aminotransferase)	38.1	14-55	12/60	7.7	8.8	ND	4.0-12.7	29	54	94
	27.8		Kinetic, UV	9.8	10.8	ND	5.0-14.3	27	133	86
	36.4		All	8.3					215	
	116.2	56-395	12/60	3.8	4.1	ND	1.0-6.1	28	54	94
	86.5		Kinetic, UV	5.5	6.4	ND	2.9-9.0	21	120	93
	106.7		All	4.7					210	
Glutamic pyruvic transaminase (Alanine aminotransferase)	27.1	3.1-40	Kinetic, UV	10.6	16.6	D<	2.1-21.4	30	120	97
	28.5		All	13.5					189	
	134.2	41-149	Kinetic, UV	5.0	8.6	D<	3.0-12.5	21	119	99
	134.1		All	5.4					183	
Lactic dehydrogenase	153.8	54-200	12/60	3.7	5.6	ND	2.3-7.7	27	63	98
	123.2		Kinetic, UV	7.1	8.0	ND	2.7-10.5	28	122	92
	129.4		All	5.3					262	
	388.3	328-641	12/60	2.7	3.0	ND	1.1-4.6	14	63	92
	324.8	201-325	Kinetic, UV	4.9	8.3	D<	2.0-10.3	10	120	95
	351.6	328-641	All	3.9					260	
Lipase	0.78	0.23-3.4	All	29.2	19.5	D>	7.10-22.10	9	85	31

Definitions and abbreviations are the same as for Table 1, except for the use of the RSD (relative standard deviation) in place of the SD (standard deviation).

Division of Travenol, Inc., Costa Mesa, CA 92626) through an in-state distributor (Laboratory Supply Corporation, Pittsburgh, PA 15213). Direction for the program is provided by a committee of pathologists and clinical chemists appointed yearly by the president of the PACP.

During our study, 194 laboratories participated in the program, of which 108 are located in Pennsylvania. Most laboratories submitted data for periods of 9 to 13 months, but a few participated as briefly as 1 month or as long as 15 months. The comparison group of 61 laboratories submitted data on separate pools for between 6 and 18 months during 1974 and 1975.

The computer program used by PACP produces for each participant laboratory a cumulative mean and a pooled SD. This pooled SD is an average monthly SD weighted by the number of analyses performed each month. Thus, it reflects day-to-day precision over the period of time the laboratory is used for a typical inpatient, and is free of effects of slowly changing systematic bias over the longer period of the entire study. Similarly, method pooled SDs, reported here, represent the weighted average monthly SD of laboratories using that method.

Comparison SDs were derived by Kurtz *et al.*[2] by averaging monthly SDs from a particular laboratory whenever separate monthly statistics were available; otherwise, the cumulative SD for the entire period was used. Weighting was not possible in that study because information about the number of analyses was not uniformly available.

No attempt was made in our study to calculate the dispersion of SD values or to remove outliers as was done in the comparison study. In each study enzyme data were processed identically with those of other constituents, except that the relative standard deviation (RSD; coefficient of variation) was used to facilitate comparison of precision in the face of differing enzyme units.

Methods selected for comparison were those previously chosen in the comparison study and do not necessarily represent either those most commonly used by PACP participants or those that are most precise. For each constituent and enzyme, a precision figure representing the average SD of

all PACP participants regardless of method is also reported.

Results

Tables 1 and 2 include the PACP and comparison SD values for chemical constituents and RSD values for enzymes. Each PACP value is compared to the one reported in the comparison study from the group of pools whose range includes the PACP mean.

Values for SD or RSD are compared by an approximate test of SD differences, by which differences are considered significant only when one of the test SD pairs is 1.5 times greater than the other.[2] True f-testing was not performed because of lack of data about the number of analyses in each comparison group.

The percentage of PACP participants whose SD or RSD values lie within the "most common" range of comparison laboratory values is listed. The "most common" range includes at least 75 percent of the comparison laboratories.

Discussion

The tabulated comparisons show that in 97 instances, there is no demonstrable difference between PACP participants and comparison hospitals; in 5 instances, PACP precision is better; and in 3 instances, the precision of the comparison hospitals is better. This distribution is approximately what would be expected according to chance alone were the groups performing at equivalent precision levels, with p less than 0.05.

For most constituents, the SD values of both groups are in close correspondence. Further, for most constituents and enzymes, the percentage of PACP participant laboratories with precision in the "most common" range approaches or exceeds 75 percent. This result is remarkable because outliers, which affect this count considerably, have not been excluded from the PACP data.

We conclude that the group of laboratories participating in the PACP program exhibit state-of-the-art precision that is indistinguishable from the comparison group of tertiary care laboratories. This close agreement of precision performance between general laboratories and university hospital laboratories has been demonstrated for 10 of 14 nonenzyme constituents, using multigroup data from the College of American Pathologists Quality Assurance Service[2] and also using results from the College of American Pathologists national clinical chemistry survey.[4]

Our study, which is the first to use data from a single, state society sponsored program, has yielded comparison information for 27 commonly analyzed constituents, including the first enzyme comparisons.

Studies such as the one we conducted give an indication of existing intralaboratory precision, but they do not answer the fundamental question of whether existing precision is sufficient to support medical decision making. Definition of acceptable precision limits must rest finally on concepts of medical usefulness. The cooperation of clinicians with laboratory investigations attempting to define medically useful limits of precision[5] is essential. Only in this way can laboratories reach the middle ground of realistic precision performance, avoiding on one side the errors caused by imprecise data and on the other the increased costs of medically unnecessary precision.

Although average precision levels reported here should serve as reassurance of the general level of performance of participant laboratories, patient care decisions should be made only with knowledge of the precision levels being obtained specifically by the individual laboratory. This information should be readily available from each laboratory director or his designated quality control supervisor. □

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Pittsburgh poison center hub of state network

Patti Adami, Assistant Director
Department for Specialty Societies

"Poison control is not just a pediatric concern, but is the concern of the physician who handles adolescent, adult, and even geriatric patients," says Richard W. Moriarty, M.D., director of the National Poison Center Network in Pittsburgh. A native of Pittsburgh, Dr. Moriarty has spent much of the past six years developing and operating the National Poison Center Network, which he founded in 1971.

Dr. Moriarty first saw the need for an organized poison control center during his internship at Children's Hospital in Pittsburgh.

"The Poison Center at that time consisted of a telephone and some source books. Without a full-time physician to staff the Center, it was disorganized and the quality of care varied."

When he became chief pediatric resident at Children's Hospital in 1970, Dr. Moriarty decided to devote much of his time to developing a more efficient and comprehensive poison center. A generous grant from the Allegheny Foundation made it possible to hire staff for the Center.



The National Poison Center Network now links 28 major poison centers, 13 universities, and more than 150 hospitals nationwide. The Pittsburgh Poison Center is a department of the Children's Hospital and is affiliated with the University of Pittsburgh. It is the national headquarters for NPCN and the regional center for Pennsylvania.

Three kinds of facilities are linked together in the National Poison Center Network: regional centers, satellite centers, and member hospitals. The Pittsburgh Regional Center is linked to a network of 7 satellite centers located in Altoona; Danville; Erie; Huntingdon, West Virginia; Youngstown, Ohio; and Binghamton, New York, and to 28 member hospitals.

Satellite centers are staffed and equipped much like regional centers and have their own network of member hospitals. Emergency rooms of member hospitals are staffed by professionals trained in the management of poison emergencies. Each emergency room is equipped with a telecopier which links it to the regional center or nearest satellite center.

When a call comes into a regional or satellite center about a suspected poisoning, the center obtains all the necessary information from the caller. In most cases, treatment can be carried out in the home, but if professional medical attention is needed the center refers the case to the nearest member hospital. While the patient is en route to the hospital, vital information about the victim, the suspected poison, and recommended treatment is transmitted via telecopier from the center to the member emergency room. By the time the patient arrives, the emergency room staff is ready with all the necessary information and equipment for treatment.

"The purpose of the network is twofold," explains Dr. Moriarty. "The first and most important purpose is to give the public a place to call in the event of a poison emergency at home.

"Our studies show that 85 percent of all poison emergencies can be handled at home. We want the public to call their nearest poison center first. Then, if it is determined that the victim needs hospitalization, the poison center staff can tell them which hospital to go to and alert that hospital to prepare for the emergency."

The second responsibility the center has is to the physician.

Pennsylvania Poison Center Network

Pittsburgh Poison Center
Children's Hospital of Pittsburgh
(412) 681-6669

Satellites:

Altoona Region Poison Center
Mercy Hospital
(814) 946-4711

Huntingdon Poison Center
(304) 696-2224

Lehigh Valley Poison Center
(215) 433-2311

Mahoning Valley Poison Center
St. Elizabeth Hospital
(216) 746-7231

Northwest Poison Center
St. Vincent Health Center
(814) 459-4000

Susquehanna Poison Center
Geisinger Medical Center
(717) 275-6116

Southern Tier Poison Center
Binghamton General Hospital
(607) 723-8929

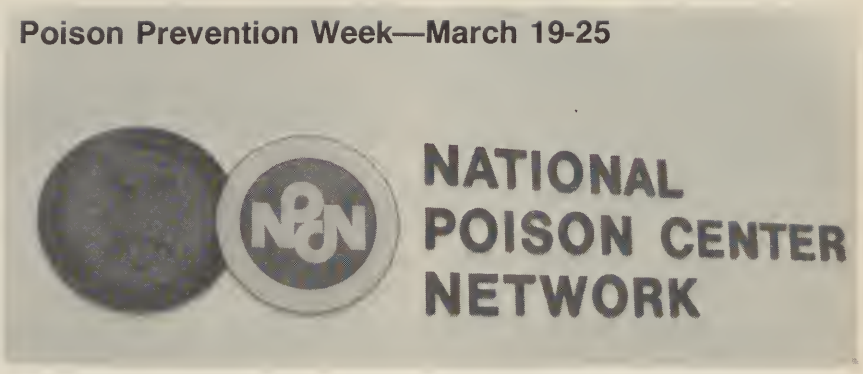
"Few physicians have the training and resource materials available to handle serious poison emergencies," says Dr. Moriarty. "But a simple telephone call to the nearest regional or satellite center will supply the doctor with the information he needs about the ingested poison and recommended antidotes."

Dr. Moriarty stresses the need for the physician to recognize that they are not just dealing with the three-year-old who drinks a bottle of furniture polish, but a whole spectrum of poisoning cases from drug abuse and suicide attempts to prescription mix-ups.

"The physician must realize that accidental ingestions are not always accidents, but may indicate child abuse. This points up the need for the physician to get involved in the educational aspect of poison control to be able to identify and treat these unusual poisoning cases."

The Pittsburgh Regional Center conducts educational programs to teach physicians, nurses, pharmacists, paramedics, and other allied professionals to manage poison emergencies. The Center also publishes ten times a year the NCPN Poison Information Bulletin, which features pertinent articles on poison treatment.

Poison Prevention Week—March 19-25



The Pittsburgh Poison Center shares its telephone number with the Pharmaceutical Profile Center. Medical professionals can call 24 hours a day, 7 days a week for information about drug interactions, compatibility selection, and related drug questions. There are two such centers in Pennsylvania. One is a department of Mercy Hospital of Pittsburgh and is affiliated with Duquesne University School of Pharmacology. The newest center operates out of the Williamsport Hospital in Lycoming County.

Combining the staffs and facilities of the Pittsburgh Poison Center and the Pharmaceutical Profile Center provides a wide range of expertise and knowledge of poison and drug management.

But does the National Poison Center Network work?

Prior to the start of the program, the Pittsburgh area averaged three deaths a year from accidental poisonings. In the past five years, not one child under the age of five has died from accidental poisoning.

"There's no doubt about it, the system does work," says Dr. Moriarty. "And I believe the more physicians know about it and use it, the more effective it will be."

NEW YORK UNIVERSITY POST-GRADUATE MEDICAL SCHOOL
announces the following AMA and AAFP approved seminars

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Patient Management Problems and Demonstration Workshops

Wednesday to Friday — May 17 to 19, 1978

Course Director: Dr. Michael J. Freedman

This course is designed for physicians (who are not hematologists or oncologists) to assist them in updating their diagnostic and therapeutic skills for the effective management of patients with hematological diseases and malignancies. Special emphasis is on the practical application of newer techniques of diagnosis and treatment in both the office and hospital setting. Morning sessions include core lectures stressing the latest clinical concepts in hematology/oncology. The afternoon program consists of commonly encountered patient management problems using the case study method, and audiovisual demonstrations of morphologic and laboratory diagnosis. A written syllabus supplements the instructional materials. Ample time is provided for questions and discussions from course participants.

GUEST SPEAKER. William B. Castle, M.D., Francis W Peabody Faculty Professor of Medicine, Emeritus, Harvard University

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Fee: $250

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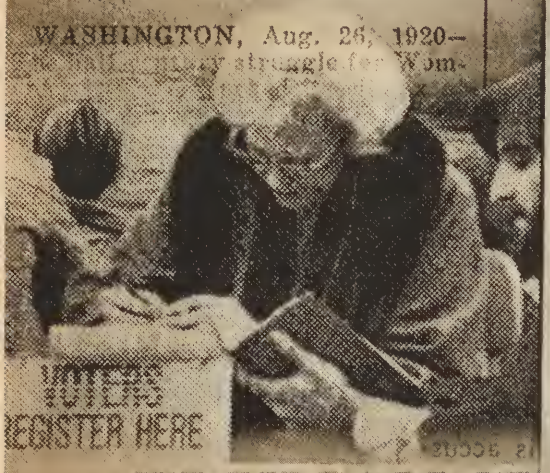
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MILITANTS VEXED AT PRIVACY.

Wanted Movies of Ceremony, But Both Factions Are

WASHINGTON, Aug. 26, 1920—



Social Security Bill Is Signed; Gives Pensions to Aged, Jobl

Roosevelt Approves Message Intended to Benefit 30,00 Persons When States Adopt Cooperating Laws–He C the Measure 'Cornerstone' of His Economic Progran

WASHINGTON, Aug. 14, The Social Security Bill, pro a broad program of unemplo insurance and old age pe and counted upon to benefi 20,000,000 persons, became l day when it was signed by dent Roosevelt in the prese those chiefly responsible fo ting it through C s.

Mr. Roosevelt cal m "the cor erstone s whi is being m s c ple ri to

SENATE APPROVES 18-YEAR OLD VOTE IN ALL ELECTIONS

Amendment to Constitution is Sent to House, Where Passage is Expected

WASHINGTON, March 10, 1971—The Senate approved today, 94 to 0, and sen

TRUMAN CLOSES TED NATIONS CONFEREN TH PLEA TO TRANSLATE CHARTER INTO DEEDS

NEW WORLD HOPE

President Hails 'Great Instrument of Peace,' Insists It Be Used

HISTORIC LANDMARK

Meeting Gives Standing Ovation as Executive Pictures Peace Gain

"If we fail to use it," he declared to the solemn final meeting of the delegates, 'we shall betray all of those who have died in order that we might meet here in freedom and safety to create it.'

"If we seek to use it selfishly—for the advantage of any one nation or any small group of nations—we shall be equally guilty of that betrayal."

Fervent Interpolation

The President, speaking in the auditorium of the War Memorial Opera House, built in memory of sons of the Golden Gate city who gave their lives in the first World War, in which he himself served, seemed to give unconscious expression to the solemn feeling of the occasion when, at the outset of his speech, he interpolated the words, half a hope, half a prayer:

"Oh, what a great day this can be in history!"

Just before the plenary session

SIGN

the Draf Ends No

WASHINGTON, Jan. 27, 1973—"With the signing of the peace agreement in Paris today, and after receiving a report from the



PATIENT PACKAGE INSERTS: A CONCEPT WHOSE TIME HAS COME?

The consumer's right to know is an irreversible and desirable trend of the Seventies. It extends, and properly, to a patient's right to know more about his or her prescription medications. One way, gaining favor, is through patient package inserts. Wisely-prepared and properly distributed when medically indicated, they could markedly improve patient knowledge and drug therapy—laudable goals by anyone's standards.

The PMA endorses these goals and will work with government, the health professions and consumers to achieve them.

The Advantages

The concept holds promise of benefits: better patient understanding of the product prescribed, better adherence to the treatment plan, and more awareness of possible side reactions.

Every doctor has had patients who fail to finish antibiotic regimens because they feel better. Some patients assume that if one tranquilizer or analgesic is good, two may be twice as good. Still others fail to report dizziness while on antihypertensive therapy —and so on.

Problems like these might arise less often if the patient received written information in addition to verbal instructions. Some studies suggest that patients are more receptive to such materials, and they more often understand the verbal instructions and follow them, when inserts are used.

The Disadvantages

There are also some potential problems. Obviously, the inserts must be clearly phrased, without extraneous or complex detail. How much information is enough? How can it be kept current? Should all patients receive the same information? Should inserts be included with all drugs? Should only potential problems be listed or are patients better off with a "fair balance" presentation that describes usefulness as well as drawbacks?

These and similar questions require answers, since model inserts have yet to be properly developed and tested. Despite the need for these studies, the FDA is proceeding prematurely with inserts on selected products. We think the Congress is the only place where the matter can be given the proper legal status and direction, particularly since it represents a conceptual change in the legal, medical and social framework of the nation's prescription drug information system.

The Solution

The PMA believes that carefully-devised pilot studies of various kinds of inserts are needed. They should be developed and implemented with full participation by doctors, pharmacists, consumers, communications experts and the drug industry. Such studies will provide reliable pathways to follow, so that inserts will be useful aids to medical practice.

And particularly we think that you should be closely involved in this debate and in these studies and decisions. Otherwise, people with less experience and qualifications may control the purposes, content and use of a tool with considerable promise for improved patient care. It could make a difference in your practice tomorrow, and more importantly, in the health of your patients.

PMA
THE PHARMACEUTICAL MANUFACTURERS ASSOCIATION
1155 FIFTEENTH ST., N. W., WASHINGTON, D. C. 20005

Create atmosphere encouraging employe self-motivation

Leif C. Beck, LL.B., C.P.B.C.
Vasilios J. Kalogredis, J.D.

Many studies and publications have attempted to define the complexities of human behavior within an organization. No theoretical solution, however, may be applied to all organizational and motivational problems.

In this article, we outline some theories and assumptions about individuals which can be applied to the administration and management of medical office personnel.

Needs—motivation theory

Abraham Maslow, a well known authority in the field of motivation, wrote of a hierarchy of human needs which provide the basis for motivation underlying individual activity.

He postulated that there are successive levels of human needs and that the need which is prevalent or dominant at a particular time governs the effort exerted to achieve a given objective. Once a need has been satisfied, it can no longer serve as an effective motivator. As one set of needs is satisfied, however, another set emerges to serve as the dominant motivator of behavior.

Maslow identifies these five basic sets of needs, which emerge in a given order, according to their priority:

• **Physiological**—Man's need for food, water, air, rest, shelter, and exercise is most basic. If an individual is hungry, he will expend his last ounce of energy to obtain food. Thus he is strongly motivated to obtain things which help satisfy this need. Once satisfied, he is no longer motivated to expend much effort in obtaining more food or water. This illustrates a key concept of Maslow's motivational theories: *a satisfied need is not a strong motivator of human behavior.*

• **Safety or security**—The need for safety or security requires physical and emotional security and freedom from deprivation and threat. The individual must feel that he is getting "the fairest possible break." When physiological needs are satisfied and therefore no longer motivating, the safety or security need becomes the primary motivator.

• **Social**—An individual's social needs may be met when he feels a sense of belonging to a group and an association with fellows; when he is accepted by peers; and when he is able to give and receive friendship and love.

• **Ego**—Ego needs fall into two categories: (1) the need for self esteem, self respect, self confidence, autonomy, competence, and knowledge (basically, a feeling that one matters as an individual); and (2) the needs for reputation, status, recognition, appreciation, and the respect and praise of fellows.

• **Self fulfillment**—Maslow's hierarchy culminates in the need for self fulfillment. The need becomes operative only when all four lower level needs have been satisfied. This final requirement is met when one is allowed and able to realize his highest potential and to continue his growth and development.

Because this highest level is the goal that should be sought by and for all employes, we will examine the traits of the self-actualizer.

The lower level needs of the self actualizer have been, or are being, met and thus he is motivated by his own need for continued self development and fulfillment.

What are some of the characteristics of such an individual? He accepts himself as he is, knows his strengths, and builds upon them; he acknowledges his mistakes and failures and accepts them for what they can teach him; he recognizes that he is human, less than perfect, and therefore takes advantage of constructive criticism and suggestions.

A self-actualizer is realistic, aware of his capabilities and those of others. He knows what can be done.

He is tolerant of uncertainty and change. Not afraid of new ideas and conditions, he is willing to be innovative and to function within new parameters. He accepts others as they are and is willing to work wholeheartedly and closely with new personnel. He is not afraid to make independent decisions.

The self-actualizer is committed to work and goes beyond the call of duty because of a belief in what is being done.

Finally, the self-actualizer is appreciative. He has a genuine interest in others and is grateful for the richness of life and the opportunity to be, to feel, to know, to do, to create, and to become.

Operating under the hierarchy of needs approach, the function of a medical office personnel manager or administrator becomes a process not of motivating staff members but of finding out which level of need is felt most strongly by each person. An attempt should then be made to provide conditions which will enable each individual to satisfy his strongest need, while at the same time satisfying the organization's need for performance from the individual. Thus organizational leadership is not a manipulative but a facilitative process.

Theory X

Douglas McGregor, another expert in the field of motivation and organizational behavior, did much to over-

The authors are the principal consultants of Management Consulting for Professionals, Inc., Bala Cynwyd.

turn traditional theories of behavior. It was McGregor's belief that the conventional conception of organizational leadership's role in directing human energy toward organizational goals had been based on at least three assumptions about human behavior with which he disagreed.

This set of assumptions, which he termed "Theory X," are as follows:

1. Average human beings have an inherent dislike for work and will avoid it if possible
2. Because of man's dislike for work he must be coerced, controlled, directed, manipulated, or threatened with punishment in order to put forth satisfactory effort toward accomplishing the organization's objectives
3. The average person prefers to be directed and wishes to avoid any responsibility. He has little or no ambition and wants security above all

Theory X had long been the accepted approach to motivation and productivity. In McGregor's mind, Theory X merely demonstrates what happens to employe productivity as a consequence of management's application of the philosophy espoused by Theory X. The factors underlying motivation (cause) and the evidence of motivated productivity (effect) were ignored in Theory X.

McGregor drew from Maslow's needs-motivation theory and his studies on motivation. He noted that for all practical purposes, physiological and safety/security needs have ceased to exist in our society. Managers and physicians often wonder why their employes are not more productive. They receive good wages and excellent fringe benefits, have good working conditions and steady employment. Yet in many instances individuals are not willing to put forth more than minimum effort.

Because physiological and safety needs have been provided for, the motivational emphasis in today's society has shifted to the social and, in some instances, to the ego need level. Unless work provides an opportunity to satisfy these higher level needs, employes will feel deprived and their behavior will reflect this feeling.

If management continues to focus attention on physiological needs, employes will make consistent and unreasonable demands for more financial rewards. Money becomes more important because it enables purchase of material goods and services that may provide limited satisfaction of the thwarted higher needs. In reality, money has limited value in satisfying most higher level needs. It can become the focal point of interest, however, if it is the only means for obtaining satisfaction.

It is important to note that management cannot provide self respect or self fulfillment; it can only create conditions to allow and encourage employes to seek satisfaction for themselves. Too often, however, conditions thwart such improvements.

Management cannot provide self respect or self fulfillment; it can only create conditions to allow and encourage employes to seek satisfaction for themselves.

Theory Y

In light of current social conditions, McGregor reasoned that management needs a different set of assumptions. His more humanistic approach is termed "Theory Y."

Theory Y is based on the following assumptions:

1. The expenditure of physical and mental effort in work is as natural as rest and play
2. People are not by nature passive or resistant to organizational needs. In some cases they have become so as a result of past organizational experiences
3. The motivation, the potential for development, the capacity for assuming responsibility, and the readiness to direct behavior toward organizational goals are present in all people—management does not put them there. Thus a manager or supervisor is responsible for making it possible for individuals to recognize and develop those human characteristics for themselves
4. The essential task of a leader is to arrange conditions within the organization so that employes can best achieve personal goals by directing their efforts toward organizational objectives

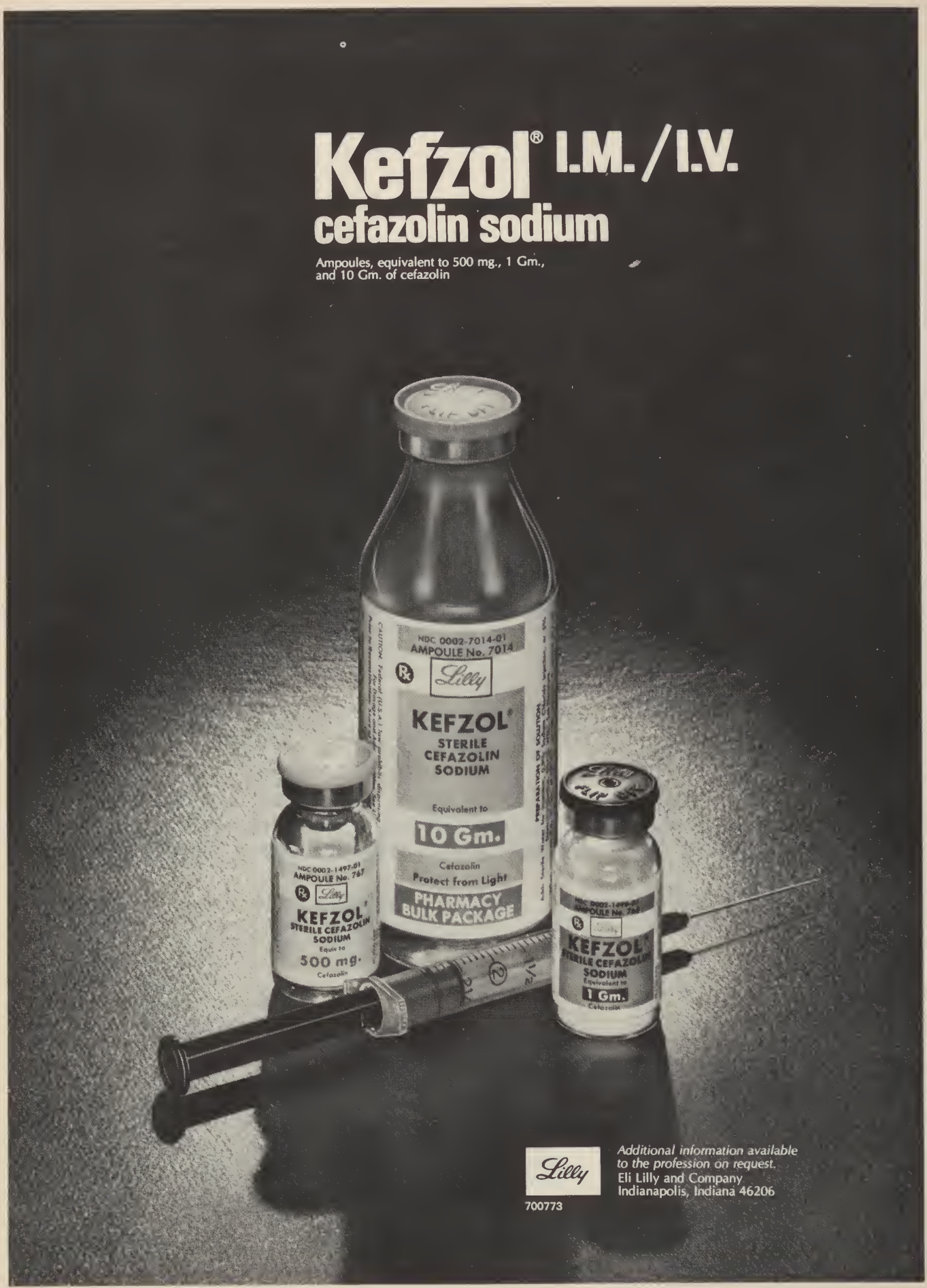
Theory Y thus suggests a process of creating opportunities, releasing potential, removing obstacles, encouraging growth, and providing guidance. While Theory X represents a static and somewhat pessimistic view of people, Theory Y is optimistic and humanistic, reflecting a feeling of unlimited potential for personal and organizational growth. It is more dynamic and amenable to the changing nature of organizational and individual needs.

The ideas outlined above, while theoretical, are of very real importance to the effective management of an organization. The medical practice setting is no exception, and with a knowledge of these concepts the physician and his staff may become more effective leaders of personnel. □

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editorials

Health care costs quality—no easy answers

The continuing debate on how to arrive at a way to provide quality health care at a reasonable cost for the American public will be with us for some time to come. Experts with all sorts of ideas will offer a spectrum of remedies to the problem, depending on whether they interpret cost or quality as the prime consideration at the moment.

If only the problem were a simple one! Consider the patient. If only he would eat the right foods, maintain a "normal weight," stop smoking, and follow a physical fitness program.

If only the country had no poverty, pollution, careless drivers, or drug abusers.

If only we had a government that trusted the private sector of the economy, that allowed free enterprise to function, with cooperation as the cornerstone for progress. The adversary position that now exists between government bureaucrats and private providers of health care perpetrates and perpetuates mistrust.

If only we had simple recognition by decision makers of the fact that rising health care costs are the result of many factors beyond the control of providers. These include malpractice, defensive medicine, mountains of paperwork, inane rules and regulations governing safety, utilization review, public accountability, inflation, and giving hospital employes wages and fringe benefits equivalent to those provided to the majority of those in the nation's work force.

If only the providers—health care professionals, health care institutions, and insurance carriers—could find enough common interest to work together for the benefit of all.

It must be apparent to all concerned that no one is going to benefit if we providers of health care remain at odds with industry, labor, and the government bureaucracy.

If we are to have a safe, sensible national health policy, lines of communication among these important groups must be maintained. The balance of power cannot be vested in any one group—least of all the faceless bureaucracy that answers to no one and will presume to plan for all unless controlled.

David A. Smith, M.D.
Medical Editor

in my opinion

What's in a name?

Here we are in 1978!

The older we get the more we appreciate the fact that we are still here, and alive. Still free to practice medicine wherever we wish; to select the hospitals we want, the specialty we desire, the patients we choose. The end of 1978 may bring us a different omen.

The new year found many of us protected by a different shield in malpractice insurance. Instead of Argonaut, which has been our insecure and forever threatening company, we are now protected by PMSLIC, our own insurance company under the aegis of the Pennsylvania Medical Society. This gives us a feeling of relief, of security, of maturity. We should be thankful to our officers for having successfully manipulated the change—quickly and wisely.

With one exception!

The word *mandatory* should have been avoided. Physicians hate to be told "You must, or else," "Do it or get out," "We don't need you," "The hell with you!" Mandatory and obligatory never have been popular words in the medical profession—and the term applied to the assessment left a bad taste in everybody's buds. Over $7 million was raised to capitalize PMSLIC, but many contributed reluctantly and unhappily. The assessment could have been "needed," "required," or "necessary" and it would have brought the same response. But doctors are an independent breed. They are tired of signing charts, or else; of attending meetings, or be dropped; of paying dues, or be suspended. They are unwilling to be commanded.

Dr. de Prophetis is editor of The Bulletin, *official publication of the Delaware County Medical Society. His commentary first appeared there.*

Assessments, like medicine, can be made more palatable when administered with gentleness and carefulness. The results are the same.

That could have been so with PMSLIC.

Rocco de Prophetis, M.D.
Chester

More questions on PMSLIC

I am submitting the following editorial as an opposite view on the way PMSLIC was handled and I respectfully request that this editorial be printed.

Robin Hood said thank you after he robbed his victims. This was my first thought when I read the

glowing account of the success of the "one-time" mandatory assessment for PMSLIC. Mandatory was wrong, immoral. It was poor management and leadership and if this mandatory assessment is not challenged who is to say that there won't be more mandatory "one-time assessments."

Even though one can agree with the philosophy of the need for PMSLIC, too many questions have been left unanswered, which leaves serious doubt in the minds of many of our colleagues on how the Argonaut dilemma came about and subsequently was handled.

In my opinion, it is the height of hypocrisy when Dr. John Blady in his letter of November 4, 1977 and again Dr. David Masland, president of PMSLIC, state that "time and again through the 129-year history of PMS we have worked together to aid segments of our membership experiencing a particular problem." We were not allowed to help; we were forced at the point of expulsion from the society.

I respect my privilege to be a member of the society but a mandatory assessment with the risk of expulsion makes our leaders dictatorial. True, more than 10,000 physicians have paid their assessments (so did I, under protest and in small coins). However, the number of physicians not paying or paying disgusted is high. Some physicians who had just joined Argonaut were caught in a double bind and I think it was wrong that none of them was advised by the PMS staff that PMSLIC was in the making. The following set of questions have been asked many times by physicians and should be answered publicly:

1. What happened to Argonaut's agreement with PMS? The explanations given by PMS staff so far have been unsatisfactory. What was Frank Hall's role in the whole affair? If it was not positive, why was he again retained?

2. Why should members who were forced to pay a mandatory assessment be expected to pay a higher selective assessment later if they don't wish to enter the company now?

3. Why wasn't there an open discussion or a vote by the membership on PMSLIC or Health Care Security, Inc., or even JUA (new vote on JUA since circumstances had changed)?

4. What are the internal operating costs and the external operating costs, such as broker and legal fees, for PMSLIC?

5. Why are *all* investments, legal, and managerial organizations located in the eastern part of Pennsylvania or New York and was there a true bidding for the best possible selection of these organizations? Are Pittsburgh's banks not good enough even though we paid a large share of the company?

6. Have other management companies, such as Corporate Risk Management, Inc., in Youngstown, Ohio been given a chance to bid?

It seems to me that the PMS staff and leaders have been so preoccupied with the PMSLIC situation that they have neglected to keep up with other developments important to Pennsylvania medicine.

For example, the state welfare department has recently upped its rates for hospital emergency room visits to $12 while the private physicians still get $6 an office visit. In addition to that, the state welfare department is putting all its medicaid billing on computers, making it very cumbersome for physicians.

To the best of my knowledge, our medical society staff had no input into the computer program and they were not involved in this new billing procedure until after the computers were already set up for the new billing procedure. We are again seemingly involved *after the fact*. Why couldn't we once be ahead of the game and practice good preventive medicine?

Walter M. Greissinger, M.D.
Pittsburgh

PMSLIC president gives answers

Dr. Greissinger's editorial regarding PMSLIC is most welcome. Welcome because it demonstrates the depth of the misconceptions regarding PMSLIC and because it gives me an opportunity again to bring to our membership the PMSLIC story.

I cannot in an editorial of reasonable length completely discuss the Argonaut dilemma, as Dr. Greissinger terms it. Suffice it to say the Pennsylvania Medical Society, as did a number of other state societies, entered into a contract with Argonaut because many of the old carriers were fleeing the state and those that remained were writing so selectively that thousands of our members faced the future without any available coverage.

Unlike other states, we yearly negotiated a five-year, iron-clad contract with Argonaut so that when the crisis hit in 1974 and Argonaut left all the other states, it could not leave Pennsylvania. This started what Dr. Greissinger refers to as the crisis. We had an unwilling carrier by the tail. It sued us to break the contract, it sued for damages, and it sued for the sheer hell of it. Argonaut went before the Insurance Commissioner one or two times each year seeking unjustified rate increases that we fought with some success. Finally last year, a negotiated withdrawal of Argonaut and replacement with PMSLIC was obtained, largely on our terms.

The House of Delegates determined to raise the necessary start-up funds by an assessment of the entire membership because this is a Society problem, not an Argonaut subscriber problem. Without Ar-

gonaut or PMSLIC in place, the Insurance Commissioner presently has the statutory power and authority to make an exclusive JUA, something 90 percent of our members said they did not want. The effect of this action would be to make it impossible for Medical Protective to do business in Pennsylvania, thereby depriving over 6,000 of our members a preferred rate.

Had a statewide JUA been declared, our non-Argonaut members would have been forced to pay many times the $250 they have been asked to contribute to capitalize our company. By ending the war of attrition with Argonaut the Society can stop the drain on its finances and use its resources to fight for tort reform in the Legislature.

Dr. Greissinger asks some questions which I'll attempt to answer. What was Frank B. Hall's role? Those who worked with Hall for the last few years can find very little to criticize and much to commend. This is particularly true of John Smither, who administered the program. Why were they retained? The contract requires that they be the broker until June 1, 1979 and there were no grounds to break that part of the contract even had we so desired.

Why a higher selective assessment to those who buy PMSLIC coverage later? This is a misunderstanding. Only those who wish to become PMSLIC insureds are required to pay the selective assessment. The formula for computing the selective assessment will remain the same no matter when a member buys insurance, but the amount of the selective assessment may change because the premium, and the territory and risk classification on which the premium is based, is subject to change.

Why not open discussions? A poll was taken of the membership and open discussions were held repeatedly in the House of Delegates. These discussions were open to all members of the Pennsylvania Medical Society.

What are PMSLIC's operating costs? External operating costs, the fee paid to Frank B. Hall, has been set at $500,000 for 1978. A maximum of $640,000 for 1978 has been established as the fee for Donald Fager Associates. It is impossible to project internal costs for 1978 at this time, because the company has no experience on which to base such figures. It can be said, however, that PMSLIC's expense ratio is expected to be about 10 percent of premium; commercial insurance companies using the independent agency system operate at an expense ratio of between 25 and 30 percent.

Why oriented to eastern Pennsylvania? Frank B. Hall is located in Philadelphia. They were the broker who found Argonaut when no other broker could find us a carrier. For the next one-and-a-half years we will be dealing with Hall in Philadelphia. In addition, over 70 percent of the claims come out of the five southeastern counties. Therefore we felt it expedient to have our operational headquarters in Philadelphia. After that time, it is planned to move the operation to Lemoyne. Ninety percent of our legal matters are handled from the Harrisburg office of Pepper, Hamilton & Scheetz.

PMSLIC is in the process of selecting an investment adviser; banks, private advisers, and insurance companies across the country, from New York and Maryland, and from all over the state, including Pittsburgh, are being evaluated.

Have other management companies been considered? Yes. Four companies presented management proposals. We chose Fager Associates of New York because: (1) they had the greatest experience with captive insurance companies—the New York captive was larger than all other captives combined until ours came into existence; (2) they were willing to give us the kind of contract we wanted; (3) they were the lowest bidder; and (4) they have maintained maximum flexibility.

Dr. Greissinger's last paragraph touches on a subject I alluded to earlier—the malpractice problem and the fight against the insurance industry have been so consuming of time, energy, and money that many other areas of even greater concern to our members have gotten less attention than might be desired, despite tremendous dedication on the part of our staff. PMSLIC should help to alleviate this problem. Again, Dr. Greissinger, thank you for calling these concerns to our attention.

David S. Masland
Carlisle

Perry County history lesson

Lest anyone think that the HMO is a new concept in medical care, the following is an excerpt from the minutes of the Perry County Medical Society:

"It was moved and seconded that that part of the fee bill relative to yearly engagements be reconsidered, which was agreed to. Then motion that articles relative to yearly engagements was eraced (sic) from said bill. Dr. Ickes then presented a motion which was seconded and passed, that all Physicians of this Society be prohibited from taking families by the year, and that this be incerted (sic) in the fee bill."

The date of this action—November 1, 1853.

To the best of my knowledge and research, this action has never been rescinded. On the other hand, neither has it been challenged in court. The good sense of the physicians of Perry County has prevailed against the passing currents of fashion.

O. K. Stephenson, M.D., Secretary
Perry County Medical Society
New Bloomfield

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100	Pavabid (150 mg.)	11.73	Papaverine HCl T.R. (100 mg.)	**4.33**	**7.40**
100	Thorazine (50 mg.)	6.03	Chlorpromazine HCl (50 mg.)	**3.23**	**2.80**
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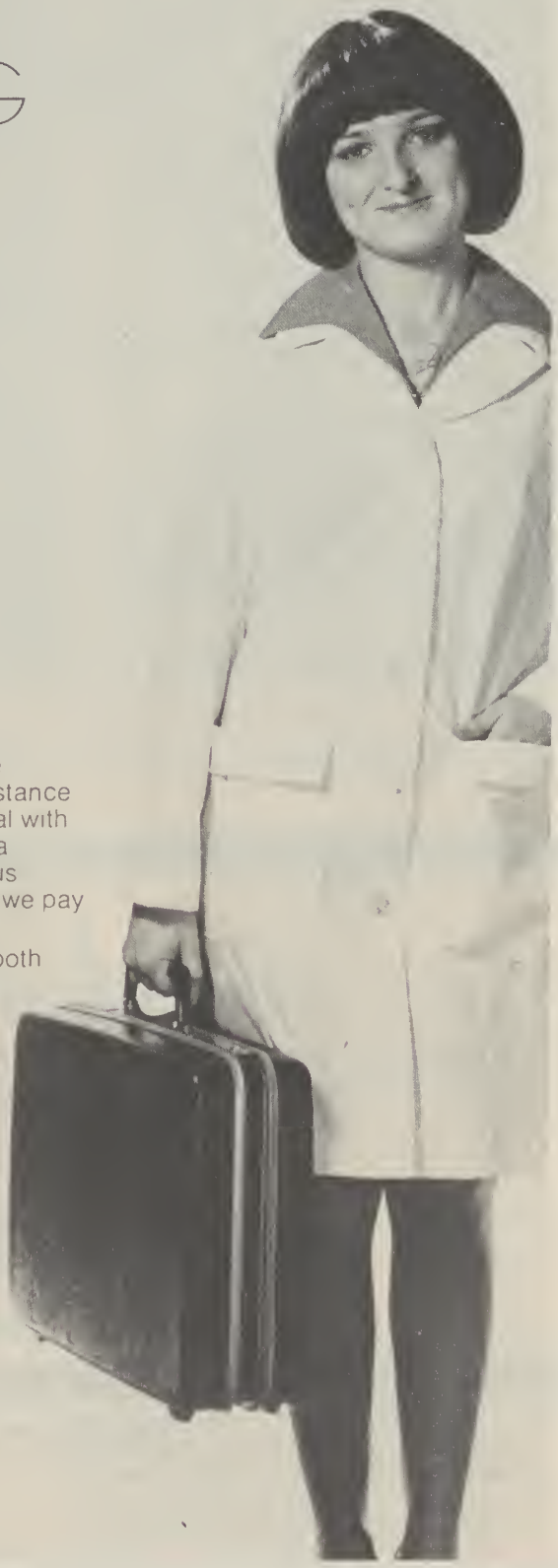
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MDs in the news

Arthur R. Taylor, M.D., Williamsport, has been elected chairman of the newly formed advisory council of the Pennsylvania High Blood Pressure Control Program. The group's objectives are to alert more people to the potential health problem, to screen greater numbers of the population, and to train additional technicians.

Richard P. Perkins, M.D., associate professor of obstetrics and gynecology at the Pennsylvania State University College of Medicine, Hershey, was named recently to head the newly established division of maternal-fetal medicine. Also named to the new division is **Paul F. Fairbrother, M.D.,** assistant professor of obstetrics and gynecology.

Luther W. Brady, M.D., chairman of the department of radiation therapy and nuclear medicine at Hahnemann Medical College and Hospital, recently was presented the Grubbe Award for his work in radiation therapy. The award, given annually to a nationally known physician for his contributions to radiology, was presented by the Chicago Medical Society and the Chicago Radiological Society.

George L. Spaeth, M.D., professor of ophthalmology at Jefferson Medical College, has authored a monograph entitled *The Pathogenesis of Nerve Damage in Glaucoma.* The 192-page text, published by Grune & Stratton in December 1977, discusses the contributions of fluorescein angiography to the diagnosis and management of glaucoma.

Stanley M. Greenwald, M.D., Philadelphia, has been named director of the new department of family practice at Frankford Hospital. Dr. Greenwald, a member of the family practice department at Nazareth Hospital since 1958, is president of the Philadelphia Chapter of the American Academy of Family Physicians.

Members of the Lackawanna County Medical Society recently selected **Peter J. Favini, M.D.,** Scranton, as president elect. **Charles J. Bannon, M.D.,** succeeded **Stanley W. Boland, M.D.,** as president. Other officers for 1978 are: **William A. Black, M.D.,** first vice president; **Thomas H. Coleman, M.D.,** second vice president; **Eugene J. Roe, M.D.,** secretary-treasurer; and **Norman S. Berger, M.D.,** five-year term on the board of directors.

The Pennsylvania State University College of Medicine in Hershey has announced the recent appointments of two assistant professors. **S. Christopher Ellis, M.D.,** a University of London School of Medicine graduate, will serve in the department of anesthesiology, where he will be a member of the cardiac anesthesia team and will direct obstetrical anesthesia. **Steven J. Wassner, M.D.,** has assumed duties as assistant professor of pediatrics and chief of pediatric nephrology at the College. He comes to Hershey from the University of California at San Francisco, where he was a research fellow in pediatric nephrology.

Robert S. Wimmer, M.D., Bala Cynwyd, was named recently to the post of director of pediatric oncology at St. Christopher's Hospital for Children. Dr. Wimmer, a Temple University School of Medicine graduate and assistant professor of pediatrics at Temple, recently completed a year as clinical fellow of the American Cancer Society at Children's.

Geisinger Medical Center, Danville, recently announced the appointments of several physicians to its staff. They are: **James E. Redenbaugh, M.D.,** associate in the department of neurology; **Faruq Mahmud, M.D.,** associate in the department of general diagnostic radiology; and **William B. Tyler, III, M.D.,** associate in the division of laboratory medicine.

Recently named as fellows of their respective specialty societies are: **Roldan G. Medina, M.D., Francis J. Duggan, Jr., M.D.,** and **Charles D. Saunders, M.D.,** to the American College of Surgeons; **Richard J. Bonacci, M.D., Arthur J. Holder, M.D.,** and **William F. Ryckman, M.D.,** to the American Academy of Family Physicians; **Gerald Bell, M.D.,** and **Norman A. Goldstein, M.D.,** to the American Academy of Facial Plastic and Reconstructive Surgery; **Fred D. Hagerty, M.D.,** to the International College of Surgeons; and **Choong Y. Wee, M.D.,** to the American College of Obstetricians and Gynecologists.

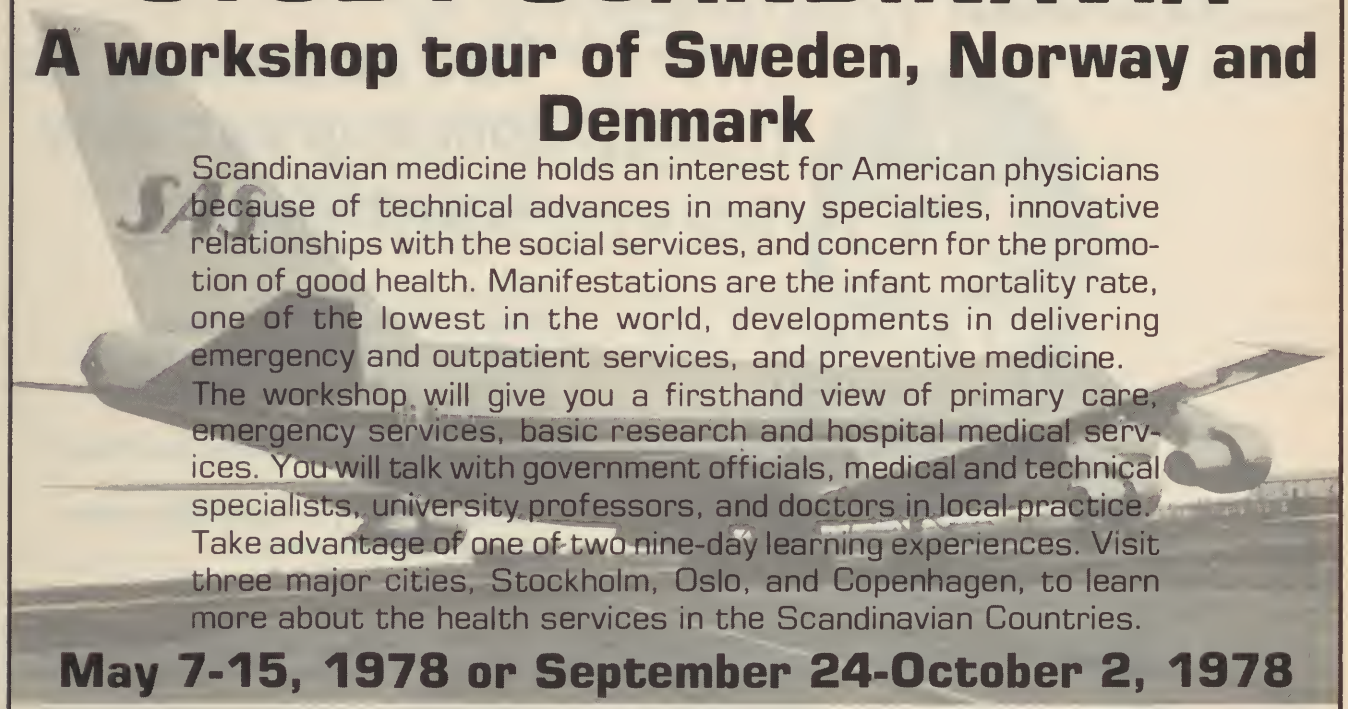
The Eastern Orthopedic Association recently announced selection of **Robert N. Richards, M.D.,** Chambersburg, as president for 1977-78. The association is composed of 1,175 orthopaedic surgeons from Maine to Florida. Dr. Richards is a staff member at Chambersburg Hospital, chairman of the Pennsylvania Committee on Trauma of the American College of Surgeons, and a member of the board of councilors of the American Academy of Orthopaedic Surgeons.

Dorothea D. Glass, M.D., Melrose Park, has been named chairman of the department of rehabilitation medicine at Temple University Medical Center. She had been acting director of the department. Dr. Glass is also a medical director of Moss Rehabilitation Hospital and chairman of the division of physical medicine and rehabilitation at Albert Einstein.

Several Pennsylvania physicians recently were named fellows of the American College of Physicians. They are: **John L. Atkins, M.D.,** York; **Joseph B. Blood, M.D.,** Athens; **Douglas P. Harr, M.D.,** Richlandtown; and **John W. Gruber, M.D., D. Barry Hey, Jr., M.D.,** and **John F. Shuman, M.D.,** all of Reading.

'STUDY SCANDINAVIA'

A workshop tour of Sweden, Norway and Denmark



Scandinavian medicine holds an interest for American physicians because of technical advances in many specialties, innovative relationships with the social services, and concern for the promotion of good health. Manifestations are the infant mortality rate, one of the lowest in the world, developments in delivering emergency and outpatient services, and preventive medicine.

The workshop will give you a firsthand view of primary care, emergency services, basic research and hospital medical services. You will talk with government officials, medical and technical specialists, university professors, and doctors in local practice.

Take advantage of one of two nine-day learning experiences. Visit three major cities, Stockholm, Oslo, and Copenhagen, to learn more about the health services in the Scandinavian Countries.

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- 10 hours Category I credit for PMS-CME membership requirement.

Cost - $980 per person, double occupancy

This travel program meets all the "guidelines for foreign convention tax expense" under the Tax Reform Act of 1976 as interpreted by the American Society of Association Executives. Under the new law, deductions can be allowed for expenses incurred in foreign travel. The limits are air fare and per diem allowances. The workshop tour can also be considered as a deduction for education to maintain and improve skills required in a trade or business. Complete attendance records and other tax deduction information will be furnished so that member physicians can consult with their accountants for deductions on individual tax returns. For full itinerary and full tax information, write to Council on Education and Science, Pennsylvania Medical Society, 20 Erford Road, Lemoyne, Pennsylvania, 17043, using the application below.

Council on Education and Science
Pennsylvania Medical Society, 20 Erford Road, Lemoyne, PA 17043

Please send me full details on the Study Scandinavia Workshop

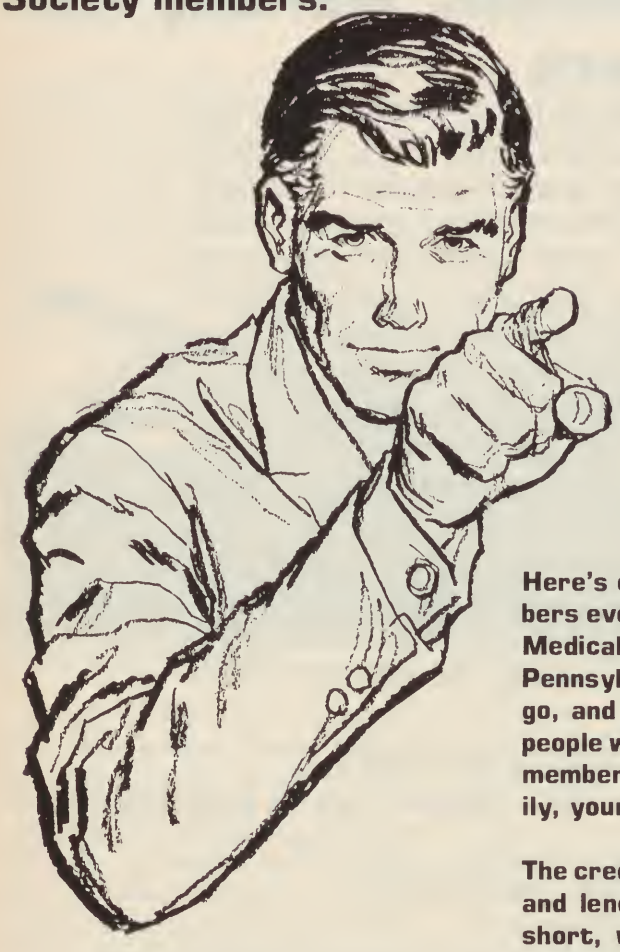
Indicate which workshop tour interests you: ☐ May 7-15, 1978
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Address: _____

Telephone: _____

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- ✓ **that can help you provide a welcome fringe benefit for your employees . . . at no cost to you**
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- ✓ **that your family and your employees' families can join, too**

Here's exciting news! In a continuing effort to bring our members every possible service and convenience, the Pennsylvania Medical Society has sought—and received—a charter for the Pennsylvania Medical Society Credit Union. It's now ready to go, and you're eligible to become a member! In fact, the only people who can become members of the credit union are Society members such as yourself, together with your immediate family, your employees and members of their families.

The credit union is designed as a convenient, cooperative saving and lending organization . . . owned only by its members. In short, when you become a member of the credit union, you become one of its owners. You have a democratic share in its management, and share in its earnings. Find out more about the credit union and how it can benefit you, your family and your employees. Clip and mail the coupon today!

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Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

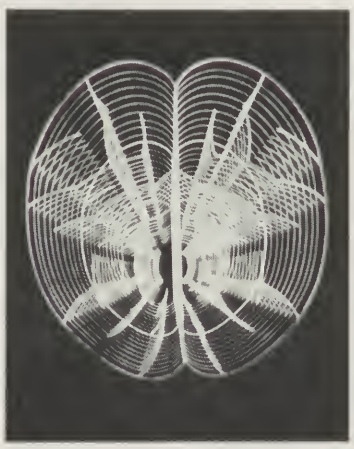
Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

Supplied: Valium® (diazepam) Tablets, 2 mg, 5 mg and 10 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available singly and in trays of 10.



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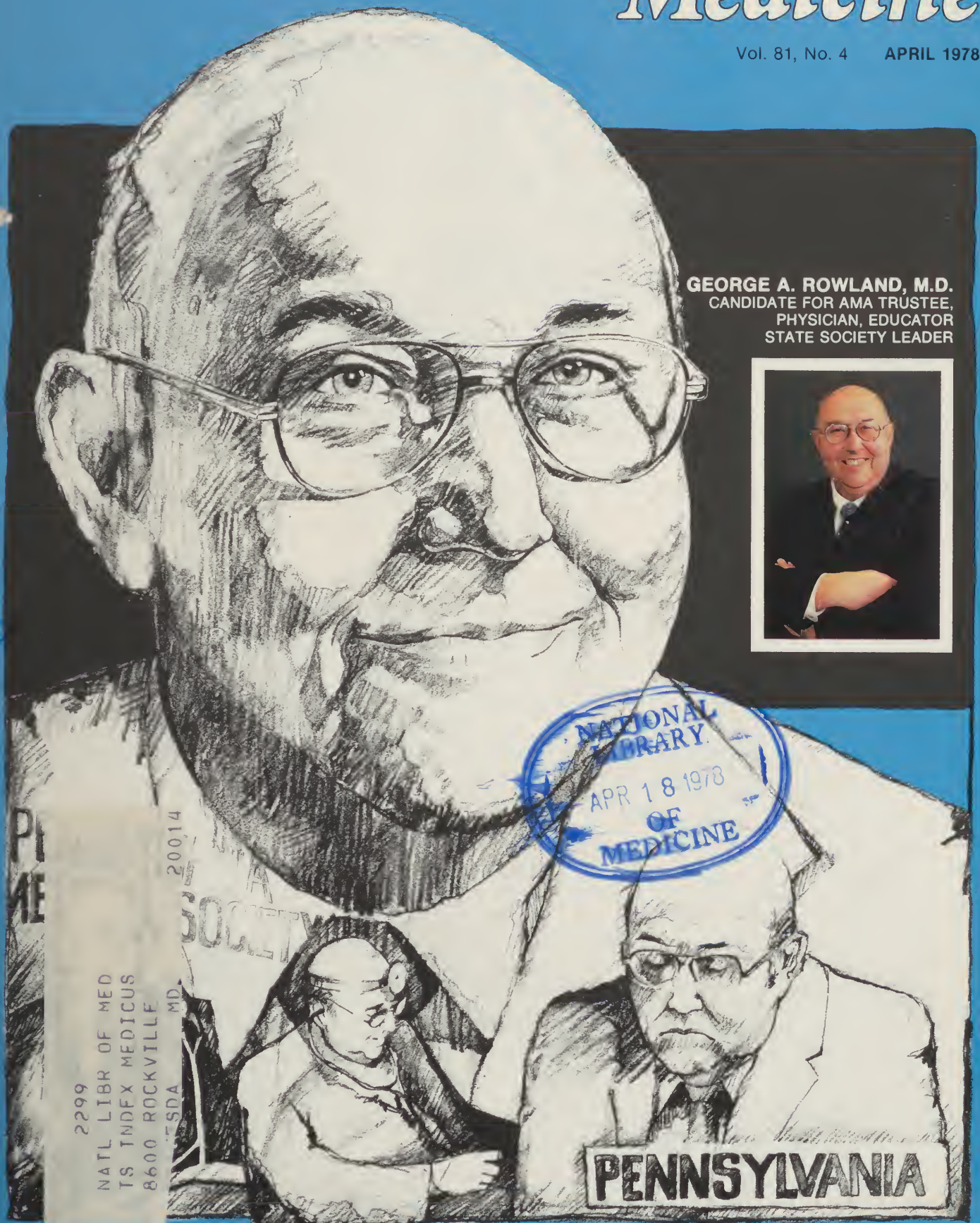
Please see the preceding page for a summary of product information.

Artist's symbolic conception of a CNS reaction to excessive stress in the overanxious patient, resulting in somatic symptoms of the gastrointestinal and cardiovascu systems. Special photographic lighting techniques were applied to a model of the brain.

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Pennsylvania Medicine

Vol. 81, No. 4 APRIL 1978



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The effectiveness of Valium (diazepam) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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ROSTENKOWSKI TO SPEAK AT OFFICERS' CONFERENCE

U.S. Representative Dan Rostenkowski of Illinois will deliver the opening address at the 1978 Officers' Conference April 12-13 at the Hershey Motor Lodge. He is chairman of the subcommittee on health of the House Ways and Means Committee, which currently is considering a hospital cost containment bill that first would test voluntary cost control methods before imposing a government cap. More than 200 physicians are expected to attend the Society's two-day leadership meeting.

HEALTH PLANNING BILLS INTRODUCED IN HOUSE

Representative James Manderino on March 14 introduced into the state House of Representatives three bills which represent the Shapp Administration's comprehensive health planning package. The first, H.B. 2120, the "Health Care Facilities Licensure Act," proposes that the Department of Health license those facilities listed in the bill.

H.B. 2121, the "Health Facilities Financial Reporting Act," gives the Department of Health responsibility for adopting rules "reasonably related to uniform systems of accounting and reporting. . .and to disclosure of the contracts or other financial arrangements between hospital providers and hospital based medical specialists."

H.B. 2122, the "Health Planning and Cost Containment Act," gives the Department of Health broad responsibilities in the certificate of need area.

House committee action is expected in the next few weeks. The Society's Commission on Health Planning currently is studying the proposed legislation.

SOCIETY SEEKS LAW FOR PHYSICIAN DEFENSE

The Board of Trustees on March 15 voted to seek legislation requiring the state to defend physicians when they are sued for reporting suspected child abuse.

At least three physicians currently are being sued for obeying the Child Protective Services Act. Although the Act provides immunity for those reporting suspected child abuse, it cannot prohibit such suits. While the physicians involved will not be held liable, they still have the burden of legal costs. The proposed legislation would put the cost of such defense on the state.

In an article on page 15 of the March issue of PENNSYLVANIA MEDICINE, Fred Speaker, the Society's legal counsel, explains immunity under such laws as the Child Protective Services Act.

RADIATION CONTROL WEEK SET FOR APRIL 30-MAY 6

The Tenth Annual Conference on Radiation Control will bring to Harrisburg leaders in the field from throughout the country between April 30 and May 6, which has been declared Radiation Control Week by Governor Milton J. Shapp.

HEALTH CARE COST CONTROL CONFERENCE JUNE 1-2

Sixty representatives of unions, industry, insurance, hospitals, and medicine will be invited to participate in a two-day conference on health care costs at the University of Pennsylvania June 1-2. The purpose of the meeting is to develop voluntary strategies for health care cost containment.

Sponsored by the Pennsylvania Medical Society, the Hospital Association of Pennsylvania, and the Pennsylvania Osteopathic Medical Association, the conference will be administered by the National Health Care Management Center of the University of Pennsylvania.

ANATOMICAL DONOR CARDS BEING MAILED BY PENNDOT

Driver's license applications being mailed by PennDOT now are accompanied by anatomical donor cards. The department is implementing a motor vehicle code amendment, urged by the State Society, to permit the attachment of such cards to drivers' licenses. The organ donor cards, when properly executed, become a permanent will and are transferable to new drivers' licenses when the current ones expire.

BOARD OF TRUSTEES REVEALS WINNERS OF SOCIETY AWARDS

The Board of Trustees on March 15 approved the issuing of several Society awards. Winners of the Environmental Improvement Awards for 1978 are Frank E. Masland, Jr., of Carlisle, and the Lehigh River Restoration Association, Inc. The Benjamin Rush Individual Award has been bestowed on Mrs. Romeo Franchini, of Pittsburgh. The Johnstown Area Mennonite Disaster Service received the Benjamin Rush Group Award.

Formal presentation of these awards will take place at the Officers' Conference Dinner on April 12 at the Hershey Motor Lodge.

SOCIETY SEEKS THREE AMENDMENTS TO ACT 111

The Board of Trustees approved on March 15 a recommendation from the Council on Governmental Relations to seek three changes in Act 111, the Medical Malpractice Act, in 1978. They are:

(1) To open Catastrophe Loss Fund coverage to professional corporations;

(2) To permit optional final binding arbitration (without appeal to court) if the parties agree in advance;

(3) To allow periodic payments of settlement claims.

SOCIETY OPPOSES LOWERING STATE DRINKING AGE TO 19

The Board of Trustees on March 15 took a position in opposition to S.B. 252 which would lower the legal age for drinking alcoholic beverages from 21 to 19. The Council on Education and Science recommended the position, citing traffic accident statistics from states which allow drinking at earlier ages as one of the reasons.

Pennsylvania Medicine

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APRIL 1978 Volume 81, Number 4

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20 Erford Road
Lemoyne, Pennsylvania 17043
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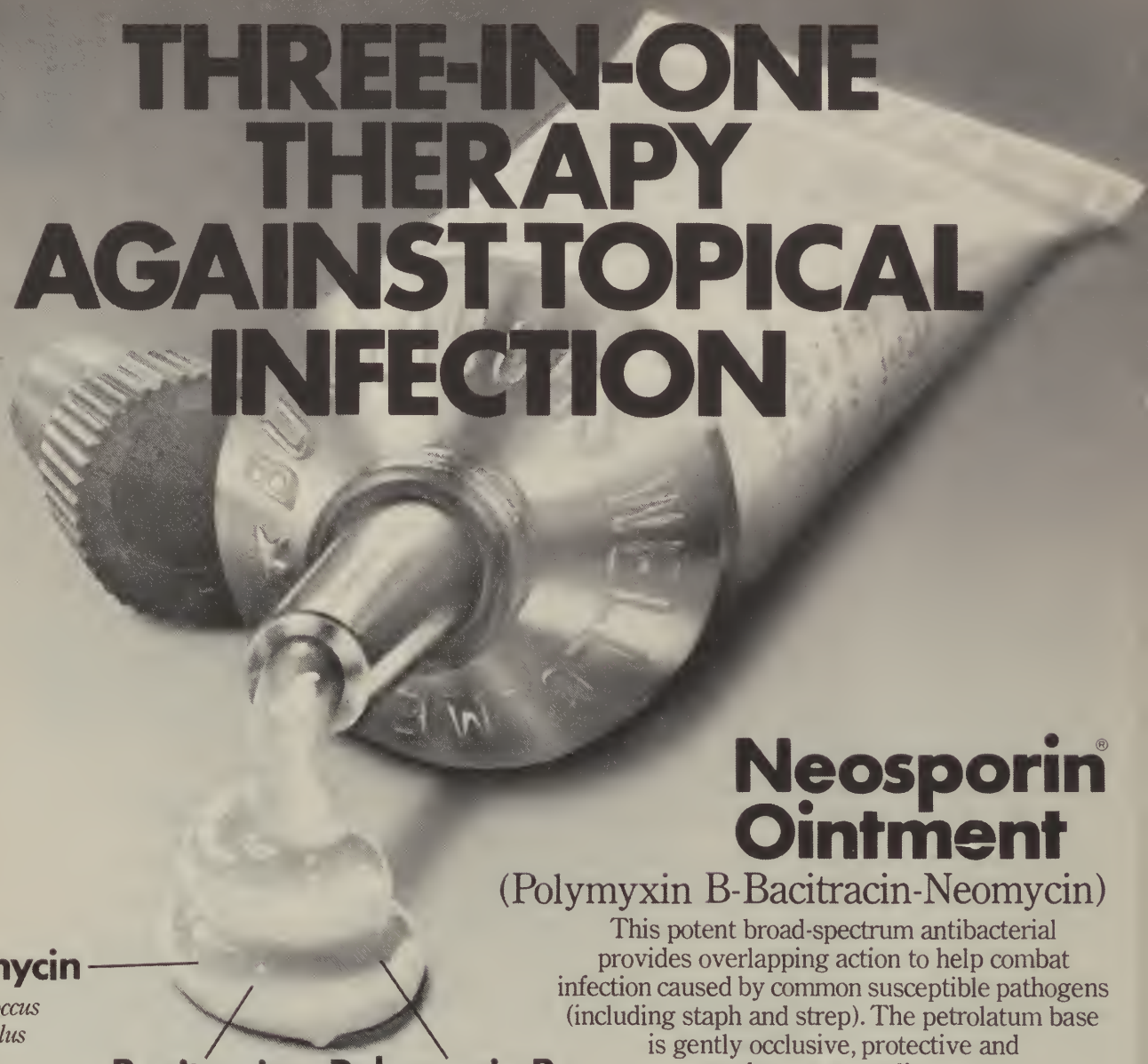
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WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.

Credit union chartered—open for business

The Pennsylvania Medical Society Credit Union was "open for business" with receipt of its charter from the State Banking Department on February 16. Those eligible for membership may now apply for participation in the program.

Membership is open to all State Society members; Auxiliary members; employes of members, the State Society and its affiliated organizations, and county medical societies; and spouses and immediate family members of those listed.

Application for membership in the Credit Union requires completion of an application form, payment of a $1 membership fee, and a contribution to the first share (savings), which carries a $5 value.



DR. WILLIAM E. WHITESELL (right), State Secretary of Banking, presents the charter for the Pennsylvania Medical Society Credit Union to William A. Shaver, M.D., Lebanon, PMS CU president.

For more information about the savings and borrowing program and for application forms, contact L. Riegel Haas, Treasurer, at the PMS Headquarters Building, 20 Erford Rd., Lemoyne, PA 17043; (717) 238-1635.

Residents' management workshop offered

A practice management workshop for residents will be held Thursday and Friday, May 18-19, 1978, at the Penn Harris Motor Inn, Camp Hill, under the sponsorship of the American Medical Association and the Pennsylvania Medical Society.

The workshop, entitled "Establishing Yourself in Medical Practice," is offered to residents entering medical practice by George Conomikes Associates. Topics will include personnel problems, patient flow techniques, physical aspects of the medical office, clinical and financial paperwork, the practice setting, and legal problems.

Residents who are PMS or AMA members or are planning to join will be charged $95; nonmembers must pay $125. Registration is limited to 35 and may be made through the office of LeRoy C. Erickson, Director of Educational Activities, Pennsylvania Medical Society, 20 Erford Rd., Lemoyne, PA 17043; (717) 238-1635.

Computers improve licensing services

The Department of State's Bureau of Professional and Occupational Affairs has computerized its record-keeping operations to provide improved service in issuing new and renewed professional and occupational licenses. Computerization has contributed to an 81 percent reduction in complaints about the Bureau's services, which include licensing of 645,574 Pennsylvanians in 22 professions and occupations.

A study of the effects of the computerization revealed that the average time needed to process license renewals dropped from 7-13 days in 1976 to 1-6½ days in 1977.

JCAH seeks physicians for hospital surveys

The Joint Commission on Accreditation of Hospitals (JCAH) currently is recruiting physician surveyors for its Hospital Accreditation Program (HAP).

Physician surveyors are responsible for the on-site review and evaluation of medical staff functions, departments, and services. They submit reports and make accreditation recommendations based on information obtained through interviews with hospital personnel, review of records and documents, and observations of the hospital's operations and procedures.

Surveyors must be licensed physicians with broadly based clinical experience and a background in hospital medical staff practices. Consultative, communicative, and data collection skills are essential.

The position affords extensive travel opportunities, although survey teams usually work two or three months consecutively in one area. Full-time surveyors work approximately eleven months per year and part-time surveyors work three months per tour of duty, subject to a minimum service of six months per year.

Physicians interested in applying for the surveyor positions, or those seeking additional information, should contact: Director of Personnel, JCAH, 875 N. Michigan Ave., Chicago, IL 60611; (312) 642-6061.



George A. Rowland seeks seat on AMA Board of Trustees

George A. Rowland, M.D., country doctor in Columbia County in the rolling hills of central Pennsylvania, is taking the next logical step in his 30-year career as a leader in organized medicine. He is a candidate for the Board of Trustees of the American Medical Association.

His colleagues in Pennsylvania view him as a man whose abilities as a leader have been finely honed by years of service at all levels of professional association activity.

In his twelfth year as a member of the PMS Board of Trustees, he has been chairman since October 1975. His fellow Board members observe that through these years he has practiced, and perfected, the ability to synthesize both sides of an issue, weigh the arguments, and lead members to consensus.

Under his leadership the PMS Board has confronted some of the most difficult problems in the Society's history, including final implementation of mandatory continuing education; the malpractice insurance crisis, culminating in the establishment of the Pennsylvania Medical Society Liability Insurance Company (PMSLIC); and the activation of Health Systems Agencies throughout the Commonwealth.

His determination to reach a solution and his ability to negotiate a favorable agreement made PMSLIC a reality, according to his fellow Board members. They agree that without the insurance company and an agreement ending the contract with Argonaut, the Society would still be involved in costly litigation to assure the availability of malpractice insurance. Instead, the Society's company is successfully launched, and PMS is moving ahead on other areas of concern.

George himself is most gratified by the Board's long range planning activities in the past three years. "We had talked about future planning and assigned the formation of objectives to committees, but it was not until the Board itself took the time to see where we were going that we had results. I believe our successes in recent years can be attributed to the long range planning sessions, where we got to know each other better, moved toward consensus on broad issues, and took a good look at the organization's mission. These meetings have proved their worth to all of us, even those who at first said without an agenda we'd never get anywhere."

To George, organized medicine is "the mechanism for the medical profession, as opposed to the individual physician, to relate to the rest of society. This role," he says, "has become as complex as society itself and has made leadership a far more demanding job."

Facing up to these demands on leadership has been the hallmark of his chairmanship of the PMS Board. Most recently he brought suit against the Commonwealth to force the release of physicians' registration fees to the State Board of Medical Education and Licensure. Traditionally this money went into the state's general fund, leaving the medical

board without resources to enforce the Medical Practice Act. PMS secured legislation to change this, but the Commonwealth dragged its feet.

"If we have to file suit to force government officials to obey the law," George says, "then that's what we should do."

Although he isn't timid in controversy, his relations with government are not always adversary. He is called on often to represent organized medicine as government deals with health issues. Currently he is a member of the Secretary of Health's Task Force on Blue Shield Regulation.

"Country doctor" is George Rowland's description of himself, but he is a man of many parts—writer, teacher, raconteur, and wit.

A native of Ardmore, a Philadelphia suburb, he completed his undergraduate work at the University of Pennsylvania and received a degree in medicine from Temple University. He served as a captain in the Medical Corps, U.S. Army Air Corps, from 1943 through 1946, mainly in the Pacific combat area.

Coming home from service, he entered the private practice of medicine and joined the staff of Bloomsburg Hospital. He was president of the hospital medical staff in 1972-73, and at various times served as secretary, chief of medicine, and chief of family practice.

Almost immediately on joining the Columbia County Medical So-



IN HARRISBURG, George Rowland fields questions in the Capitol Press Room.





IN CHICAGO, Dr. Rowland (far right) meets with the Pennsylvania Delegation at the December 1977 AMA meeting.

ciety in 1947 he became an activist in organized medicine. He moved through the offices of the society, serving as president in 1955. He was a member of the PMS House of Delegates from 1951 to 1966 when he was elected to the PMS Board of Trustees.

As editor of his county society's bulletin, a post he held for ten years, George enjoyed considerable fame, as his editorials on the affairs of the day, liberally laced with humor, were reprinted widely. Until the demands on his time became too great he wrote a column for PENNSYLVANIA MEDICINE, "Let George Say It."

In 1965 he was elected an alternate delegate to the American Medical Association, and in 1972 became a delegate. In 1976 he chaired the reference committee on medical education at the Dallas meeting.

George has been involved in educational activities throughout his professional career. Currently he is clinical assistant professor of family and community medicine at the Pennsylvania State University College of Medicine, Hershey, where he developed a course on organized medicine for second year medical students. He also had a part in developing a program of continuing medical education for physicians in rural areas and was instrumental in establishing a consortium of family practice residency programs in Pennsylvania.

"The number of family practice residency programs in Pennsylvania and across the nation is a source of great satisfaction to me," he reminisced recently. "One of the first assignments I had with the Pennsylvania Medical Society was with the Committee on Rural Health. We sought ways to interest medical students to practice in underserved areas, I enjoyed that interaction with students then, even as today I am stimulated by teaching the course on organized medicine."

IN MILLVILLE, a young patient demands the doctor's full attention.



The course gives George an opportunity to spread his convictions about organized medicine, and there's no doubt about the positive impact on the students, who say it has "turned them on" to organized medicine.

His career of leadership in the American Academy of Family Physicians and its predecessor, the Academy of General Practice, also centered around education. After serving as president of the Pennsylvania Academy of General Practice, he was for many years chairman of its Commission on Education, and used the post to improve the quality and quantity of continuing education for general practitioners in the state.

To the American Academy of Family Physicians George Rowland gave long and distinguished service. He was a member of the House of Delegates from 1967 to 1972, serving as chairman of the Committee on Scientific Assembly in 1971. He was elected to a three-year term on the AAFP Board of Directors in 1972, and was chairman of the Commission on Education from 1972 through 1974. He was elected AAFP vice president in 1974.

George and Liberty Rowland live in Millville, where he has his practice. They have four children and four grandchildren. One of their greatest pleasures is travel, often now to visit with the grandchildren, just as when the children were growing up they spent their free time camping with them.

George Rowland will bring to the AMA Board of Trustees 30 years of experience as a leader at all levels of organized medicine, a talent for diagnosing a problem and finding a remedy, a tough but rational philosophy about the role of organized medicine, and a willingness to be on the front lines in times of crisis.

Time is the test of all things.

1954
1978



BRIEF SUMMARY

Indications: Oral potassium therapy for the prevention and treatment of hypokalemia which may occur secondary to diuretic or corticosteroid administration. May be used in the treatment of cardiac arrhythmias due to digitalis intoxication.

Contraindications: Severe renal impairment with oliguria or azotemia, untreated Addison's disease, adynamia episodica hereditaria, acute dehydration, heat cramps and hyperkalemia from any cause.

Precautions: Potassium intoxication by oral administration rarely occurs in patients with normal kidney function, however, potassium supplements must be administered with caution, since the amount of the deficiency or daily dosage is not accurately known. Frequent checks of the clinical status of the patient, and periodic ECG and/or serum potassium levels should be made. High serum concentrations of potassium ion may cause death through cardiac depression, arrhythmias or arrest. This drug should be used with caution in the presence of cardiac disease.

In hypokalemic states, especially in patients on a low-salt diet, hypochloremic alkalosis is a possibility that may require chloride as well as potassium supplementation.

Adverse Reactions: Nausea, vomiting, diarrhea, and abdominal discomfort have been reported. The most severe adverse effect is hyperkalemia.

Overdosage: Potassium intoxication may result from overdosage of potassium or from therapeutic dosage in conditions stated under "Contraindications". Hyperkalemia, when detected, must be treated immediately because lethal levels can be reached in a few hours.

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20 mEq per 15 ml

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—F. SCOTT FITZGERALD
THE CRACKUP, 1936

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a shade of blue that often accompanies depression

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1. Goldberg HL, Finnerty RJ, Cole JO: Doxepin: Is a single daily dose enough? *Am J Psychiatry* 131:1027-1029, 1974.

Brief Summary of Prescribing Information
ADAPIN® (doxepin HCl) Capsules

Indications—Relief of symptoms of anxiety and depression.

Contraindications—Glaucoma, tendency toward urinary retention, or hypersensitivity to doxepin.

Warnings—Adapin has not been evaluated for safety in pregnancy. No evidence of harm to the animal fetus has been shown in reproductive studies. There are no data concerning secretion in human milk, nor on effect in nursing infants.

Usage in children under 12 years of age is not recommended. MAO inhibitors should be discontinued at least two weeks prior to the cautious initiation of therapy with this drug, as serious side-effects and death have been reported with the concomitant use of certain drugs and MAO inhibitors.

In patients who may use alcohol excessively potentiation may increase the danger inherent in any suicide attempt or overdosage.

Precautions—Drowsiness may occur and patients should be cautioned against driving a motor vehicle or operating hazardous machinery. Since suicide is an inherent risk in depressed patients they should be closely supervised while receiving treatment. Although Adapin has shown effective tranquilizing activity, the possibility of activating or unmasking latent psychotic symptoms should be kept in mind.

Adverse Reactions—Dry mouth, blurred vision and constipation have been reported. Drowsiness has also been observed.

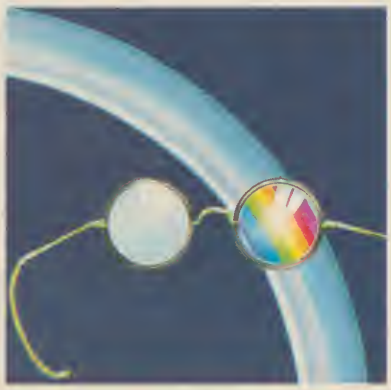
Adverse effects occurring infrequently include extrapyramidal symptoms, gastrointestinal reactions, secretory effects such as sweating, tachycardia and hypotension. Weakness, dizziness, fatigue, weight gain, edema, paresthesias, flushing, chills, tinnitus, photophobia, decreased libido, rash and pruritus may also occur.

Dosage and Administration—In mild to moderate anxiety and/or depression: 25 mg t.i.d. Increase or decrease the dosage according to individual response. Daily dosage, up to 150 mg may be taken at bedtime without loss of effectiveness. Usual optimum daily dosage is 75 mg to 150 mg per day not to exceed 300 mg per day.

Antianxiety effect usually precedes the antidepressant effect by two or three weeks.

How Supplied—Each capsule contains doxepin, as the hydrochloride: 10 mg, 25 mg, 50 mg and 100 mg capsules in bottles of 100 and 1000.

For complete prescribing information please see package insert or PDR.



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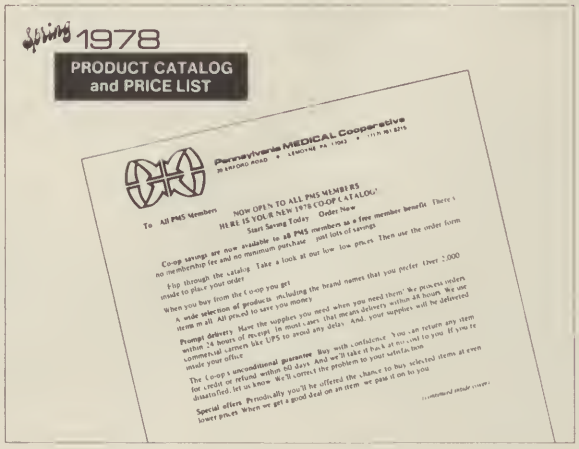
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Act 111 arbitration binds federal courts

Fred Speaker, Esq.

Two federal court decisions have declared that the federal courts have no jurisdiction to decide medical malpractice cases before there has been compulsory arbitration under Act 111.[1]

The first reported case on this subject, *Marquez v. Hahnemann Medical College & Hospital,*[2] involved an action, brought in federal district court in the Eastern District of Pennsylvania, based on diversity of citizenship—claiming that the court had jurisdiction because the parties resided in different states. Defendants were the hospital and two physicians.

When Act 111 was adopted, the legislature provided that all medical malpractice claims must first be submitted to an arbitration panel before there was an opportunity to make an appeal and have a new trial:

> The arbitration panel shall have original exclusive jurisdiction to hear and decide any claim brought by a patient or his representative for loss or damages resulting from the furnishing of medical services which were or should have been provided.[3]

Some of the legislative drafters hoped that this provision might also apply to the courts in the federal system, but they had no strong belief that this would happen.

Marquez gives great support to their hopes. In its opinion, the court stated:

> . . . The Commonwealth of Pennsylvania has closed its state courts to this action at least until the arbitration proceeding required by law is completed. This court concludes that in furtherance of the underlying policies of *Erie* [*R. Co. v. Tompkins*],[4] it must find that it lacks jurisdiction over the present case until the compulsory arbitration proceedings are completed.[5]

Concluding that:

> . . . Pennsylvania has attempted to deal with the medical malpractice crisis that confronts the Commonwealth and the nation. The Pennsylvania legislature has decided that compulsory arbitration may ameliorate this crisis. This court will not interfere with such expression of legislative intent.[6]

the court dismissed the case without saying that it could not be brought again after the arbitration process was completed.

Quite recently, in February of this year, the federal court filed an order dismissing a medical malpractice case brought against a physician, hospital, and drug company, stating that the court agreed with *Marquez* and concluding "that the Act is a bar to this diversity action."[7]

Mr. Speaker is a member of the law firm of Pepper, Hamilton & Scheetz, which serves as the Society's legal counsel.

Thus the federal district courts are saying that the compulsory arbitration provisions of Act 111 bind federal as well as state courts. The Pennsylvania Supreme Court is now considering whether it will uphold the compulsory arbitration proceedings against a constitutional attack.

[1] *Health Care Services Malpractice Act, 40 P.S.* §§1301.101 et seq.
[2] *435 F. Supp. 972 (E.D. Pa. 1976).*
[3] *40 P.S. §1301.309.*
[4] *304 U.S. 64 (1938).*
[5] Marquez v. Hahnemann Medical College & Hospital, *435 F. Supp. 972, 973 (E.D. Pa. 1976).*
[6] Id. *at 974.*
[7] Fred L. Dings, III, Administrator v. George C. Mosch, et al., *No. 77-3291 (E.D. Pa. filed February 1, 1978).*

NAIC study shows malpractice claims not related to medical specialty

Degree of malpractice risk is not related to specialty, according to a nationwide survey of 24,000 malpractice suits decided between July 1975 and June 1976.

Although malpractice insurance firms require higher premiums from specialists who perform surgery than from nonsurgeons, the National Association of Insurance Commissioners study shows that specific diagnoses and treatments, not specialties, are more often grounds for claims.

According to the report, one-third of claims were filed against physicians who performed no surgery or only minor surgery. Twelve percent of claims were filed against general surgeons and almost 13 percent were against obstetrician / gynecologists. Claims against other specialties were evenly divided and fell between 1 and 6 percent. Mistakes in diagnosis, together with errors in planning and providing treatment, were alleged in 95 percent of reported claims.

The detailed study is available in four volumes for $28, and may be ordered from the National Association of Insurance Commissioners, 1015 Clark Bldg., 633 W. Wisconsin Ave., Milwaukee, WI 53203. No plans for publication of a summary of the data have been made.

County societies name new leaders

Leadership positions in county medical societies throughout the state have changed hands in recent months. Among those installing new officers for 1978 are Armstrong, Clarion, Lancaster, Lycoming, Northampton, Somerset, and Washington County Medical Societies.

The Armstrong County Medical Society recently installed Diego Cordoba, M.D., president; L. N. Sotos, M.D., president elect; Roger Vega, M.D., vice president; and James Bauer, M.D., secretary-treasurer.

New officers of the Clarion County Medical Society are: William M. McKinley, M.D., a surgeon from Brookville, president; Arthur J. Dortort, D.O., of New Bethlehem, vice president; and David L. Miller, M.D., New Bethlehem, secretary-treasurer.

Joseph L. Eckenrode, M.D., has been elected president of the Lancaster City and County Medical Society, succeeding John L. Farmer, M.D. Other officers elected to the society are: Joseph L. Knepper, M.D., president elect; Charles L. Deardorff, Jr., M.D., vice president; and Roland A. Loeb, M.D., secretary-treasurer.

Charles F. Cipolla, M.D., was installed as president of the Lycoming County Medical Society. Officers serving with Dr. Cipolla are: Edward N. Moser, M.D., president elect; James L. Harrison, M.D., vice president; Harry L. Manning, M.D., secretary; Donald E. Shearer, M.D., treasurer; and Chan Yoon, M.D., assistant secretary-treasurer.

Harry G. Light, M.D., was inducted president of the Northampton County Medical Society, replacing George B. Laubach, M.D., immediate past president. Other new officers are: Donald H. Smith, M.D., president elect, and John H. Hobart, M.D., secretary, both of Easton; and Theodore P. Burger, M.D., vice president, and Walter K. Peters, M.D., treasurer, both of Bethlehem.

Ross St. Clair Rumbaugh, M.D., of Myersdale, was elected president of the Somerset County Medical Society. Alfred Rice, M.D., president elect, and Emiliano Limcuando, M.D., vice president, both of Somerset, and Edwin M. Price, M.D., of Confluence, complete the slate of the society's 1978 officers.

Washington County's newest officers are John F. Weldon, M.D., president; Malcolm E. Ruben, M.D., president elect; Richard E. Harcom, M.D., vice president; and Nicholas E. Fuerst, M.D., secretary-treasurer.

Dr. Byron heads Montgomery CMS

Harold J. Byron, M.D., a practicing psychiatrist in Norristown and Wyncote, was installed recently as the 131st president of the Montgomery County Medical Society. Dr. Byron is clinical assistant professor of psychiatry at the Medical College of Pennsylvania and chief of neuropsychiatry at Sacred Heart Hospital.

Retiring president John C. Maerz, M.D., was presented with the traditional engraved gavel at the installation ceremony.

Other physicians elected to office are: John J. Maron, M.D. a family physician from Pottstown, president elect; H. Craig Bell, M.D., an Abington psychiatrist, vice president; Alan L. Dorian, M.D., Norristown surgeon, secretary; and Joseph L. Hunsberger, M.D., Norristown family physician, treasurer.

Dr. Tighe begins term

Patrick L. Tighe, M.D., a south Scranton physician, has begun serving a six-month sentence for illegally dispensing controlled drugs.

Dr. Tighe was found guilty of 18 counts of dispensing biphetamines June 5, 1976 by a federal jury in Wilkes-Barre. The physician filed several appeals, the last of which was turned down in December 1977.

In 1976, Dr. Tighe was indicted for medicare fraud and subsequently pleaded guilty to those charges. He was sentenced to two years probation in that case.

Reports of child abuse nearly doubled in 1977

The number of potential child abuse cases reported to the state's toll-free "Childline" nearly doubled in 1977, according to the State Welfare Department. In the last nine months of 1976, Childline received 6,400 calls; in 1977, the figure rose to 13,800.

Philadelphia County had the most reports—4,537 in 1977 compared to 1,738 in 1976. Calls came from all 67 counties.

Under law, medical personnel are required to report suspected cases of child abuse. When a report is filed with Childline, staff members check a central register of confirmed cases to see if the child has been abused in the past. The Child Protective Service Unit in the county concerned is then notified and a caseworker investigates.

Pennsylvania's Childline number is (800) 932-0313.

Tuition for freshmen at Hahnemann Medical College will hit the $10,000 mark in September 1978, a boost of almost $4,000. Joseph DiPalma, M.D., dean of the medical school, said increases are needed to offset reductions in state and federal education subsidies.

Students already in school face an increase of $1,000 a year beginning in September. Freshmen and sophomores now pay $6,100 per academic year, while juniors and seniors are charged $5,500.

Pennsylvania's first report

Penicillin resistant gonorrhea discovered in Allegheny County

Ever since the Center for Disease Control first isolated a strain of penicillinase-producing *Neisseria Gonorrhoeae* in February 1976 and issued a general report of this occurrence in October 1976, there has been a great deal of concern regarding the spread of these organisms within the United States and throughout the world. The implication, of course, is obvious. There was fear that strains of *Neisseria* that are resistant to multiple antibiotics might eventually evolve. If this were to occur, effective therapy for the infectious disease, which is reported more frequently than all others combined, might no longer be available. It is horrifying to imagine 2.5 million cases of an antibiotic-resistant disease occurring annually in the United States in persons under 30.

It is somewhat comforting to report that, as a result of local, national and worldwide surveillance systems which were promptly established, the spread of these strains of organisms, particularly in the United States, has been limited. As of the end of September 1977, penicillinase-producing gonococci had been detected in 16 countries. In the United States 218 isolates had been reported from 26 states. There appear to be two main endemic areas, namely, the Phillippines and West Africa. The strains found in the United States appear to be related to the Far East, as determined from historical data of patients and from calculation of the molecular weight of the plasmid factor. Strains found in England appear to be related to West Africa. There has been some spread within the United States but, due to surveillance measures and prompt epidemiological investigation, this has been limited to small, local outbreaks of up to 10 to 12 cases. Outbreaks have been eliminated by prompt treatment of the cases.

The Allegheny County Health Department instituted a surveillance system in November 1976, shortly after the CDC reports were received, for the purpose of detecting penicillinase-producing strains of *N. Gonorrhoeae*. This surveillance system has been in effect since then. On November 21, 1977 the first isolate of such a strain was detected in the Health Department laboratory in a culture specimen obtained from a female patient at a Health Department Venereal Disease Clinic. The patient was treated promptly with appropriate medication and cured, and epidemiological investigation was undertaken. The source was traced to a member of the Armed Services who had recently returned from the

Continued on page 17.

INVESTMENT

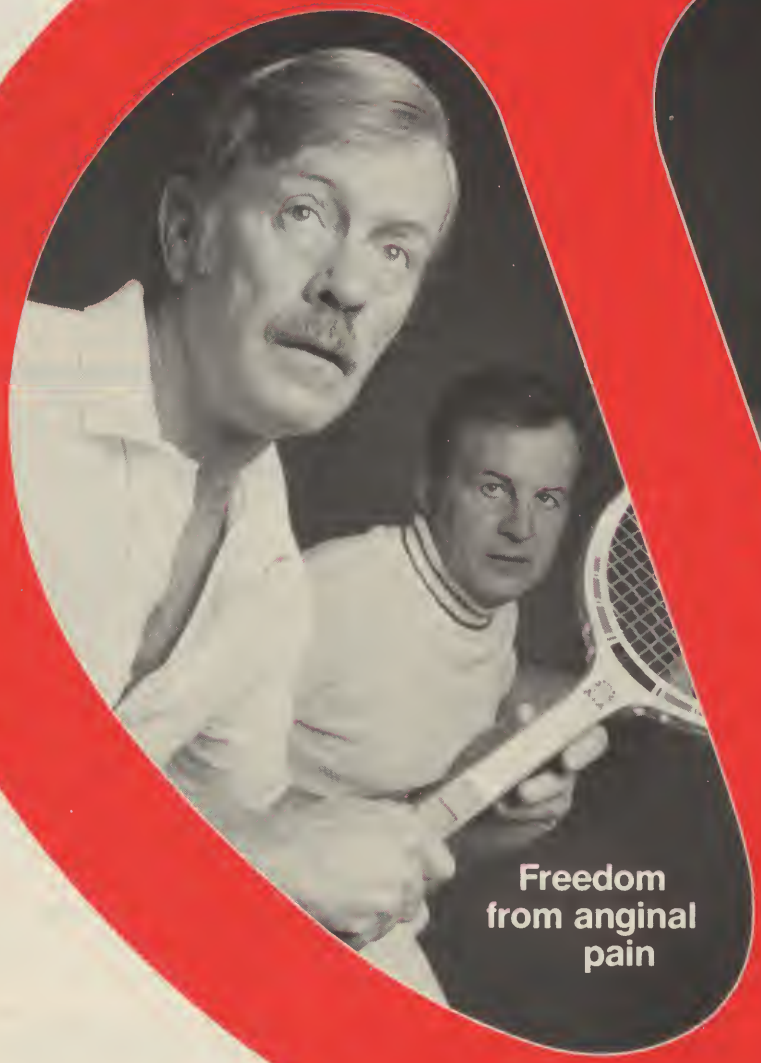


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INDICATIONS: For the prophylaxis and long-term treatment of patients with frequent or recurrent anginal pain and reduced exercise tolerance associated with angina pectoris, rather than for the treatment of the acute attack of angina pectoris, since its onset is somewhat slower than that of nitroglycerin.

PRECAUTIONS: As with other effective nitrites, some fall in blood pressure may occur with large doses.

Caution should be observed in administering the drug to patients with a history of recent cerebral hemorrhage, because of the vasodilation which occurs in the area. Although therapy permits more normal activity, the patient should not be allowed to misinterpret freedom from anginal attacks as a signal to drop all restrictions.

SIDE EFFECTS: No serious side effects have been reported. In sublingual therapy, a tingling sensation (like that of nitroglycerin) may sometimes be noted at the point of tablet contact with the mucous membrane. If objectionable, this may be mitigated by placing the tablet in the buccal pouch. As with nitroglycerin or other effective nitrites, temporary vascular headache may occur during the first few days of therapy. This can be controlled by temporary dosage reduction in order to allow adjustments of the cerebral hemodynamics to the initial marked cerebral vasodilation. These headaches usually disappear within one week of continuous therapy but may be minimized by the administration of analgesics.

Mild gastrointestinal disturbances occur occasionally with larger doses and may be controlled by reducing the dose temporarily.

HOW SUPPLIED: 10 mg chewable scored tablets, bottle of 100. Also 5, 10 and 15 mg oral/sublingual scored tablets in bottles of 100. 10 mg oral/sublingual scored tablets also supplied in bottles of 1,000.

Also available: Cardilate®-P brand Erythrityl Tetranitrate with Phenobarbital* Tablets (Scored).

(*Warning—may be habit-forming.)



Wellcome

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Penicillin resistant gonorrhea

Continued from page 15

Far East. All known contacts have been examined and given appropriate preventive treatment. No further isolates have been obtained. This is the first case to be reported in Pennsylvania. It is hoped that no further spread will occur.

It is essential that an intensive surveillance system be maintained because, even though the pencillinase-producing strains of gonococci appear to have been well contained, additional strains undoubtedly will be brought into this country. All health facilities and all physicians should be alert to the possible presence of these strains of organisms. The following guidelines should be followed:

1. Treatment of choice for uncomplicated gonorrhea in the absence of contraindications remains 4.8 million units of aqueous procaine penicillin G intramuscularly, together with 1 gram of probenecid orally.
2. Patients should return for test of cure within 3 to 7 days. Test of cure smears and/or cultures should be done whether the patient is symptomatic or asymptomatic.
3. Patients who are treatment failures, as indicated by positive test of cure smears or cultures, should be treated with spectinomycin 4 grams I.M., in the absence of contraindications to the use of the drug.
4. Repeat test of cure cultures should be obtained 3 to 7 days after spectinomycin.
5. Contact tracing should be initiated immediately on all patients with a positive test of cure culture. These contacts should be given preventive treatment with spectinomycin in the same dosage as is used in treatment of proven cases.
6. If cases are detected in which there has been a treatment failure with recommended doses of penicillin and probenecid, the Department of Health should be notified at (717) 787-3740. Facilities for beta lactamase testing are available. Epidemiological assistance will be given to anyone requesting it.
7. A special plea is made to all physicians to use only recommended treatment schedules in treating all patients infected with *Neisseria Gonorrhoeae* because treatment with subcurative doses of antibiotic has been shown to be a major reason for development of increasing resistance of the chromosomal mutation type by the organism.

Leonard B. Volkin, M.D., Director
Venereal Disease Program
Allegheny County Health Department

From the Pennsylvania Department of Health

Advisory committee recommends tuberculosis treatment

A 12-month daily chemotherapy regimen for tuberculosis patients was recommended recently by the Medical Advisory Committee on Chronic Respiratory Diseases for selected patients treated at tuberculosis clinics operated by the Pennsylvania Department of Health.

The 12-month regimen was one of several options recommended for tuberculosis patients. The options recommended by the Committee were:

1. The standard 18-month regimen consisting of Isoniazid 300 mg and Rifampin 600 mg given in a single daily dose for 6 months followed by Isoniazid 300 mg and Ethambutol 15 mg/kg given in a single daily dose for an additional 12 months. This standard regime, representing a shortening of therapy of 6 months, was adopted by the Pennsylvania Department of Health's Tuberculosis Control Program on the advice of its Medical Advisory Committee in April 1976.
2. A 12-month regimen consisting of Isoniazid 300 mg, Rifampin 600 mg, and Ethambutol 25 mg/kg for 2 months followed by Isoniazid 300 mg and Rifampin 600 mg in a single daily dose for an additional 10 months provided that the patient's sputum becomes negative during the first 6 months of treatment. (The dose of Ethambutol at 25 mg/kg may cause ocular toxicity in patients who receive Ethambutol for a long period of time. Patients on 25 mg/kg of Ethambutol must have visual acuity and color perception tests performed at monthly intervals, and it is recommended that Ethambutol 25 mg/kg not be given for long periods of time.)
3. An 18-month regimen of Isoniazid 300 mg and Ethambutol 15 mg/kg given in a single daily dose for patients who cannot tolerate Rifampin.
4. Individualized chemotherapy programs for patients with special problems in treatment.

The Committee passed these recommendations unanimously and the Pennsylvania Department of Health adopted them immediately.

The incidence of tuberculosis continues to decline at a rate of 6 to 9 percent per year and only 1300 new cases were reported in the Commonwealth in 1977. The Committee's recommendation of a shortened chemotherapy regimen applies research findings from throughout the world which indicate that coordination of Isoniazid and Rifampin, both bacteriocidal drugs, is the most effective drug regimen available for tuberculosis treatment and causes a relatively low rate of toxicity. The British have instituted a 9-month chemotherapy program as routine treatment for tuberculosis patients, and the U. S. Public Health Service has begun investigating 6-month chemotherapy protocols.

The decision by the Advisory Committee to the Pennsylvania program makes Pennsylvania one of the first states in the U.S. to significantly shorten therapy for tuberculosis. The Committee believes, however, that a decision to shorten therapy to a period less than 12 months should wait for additional data from studies now being conducted abroad and by the U. S. Public Health Service.

The Tuberculosis Control Program of the Commonwealth is administered by the office of the director of the Division of Chronic Respiratory and Occupational Disease Services. George Bereznicki, M.D., is in charge of the 70 tuberculosis clinics in Pennsylvania and advises the 80 physicians who provide patient services in these clinics.

The 12 members of the Medical Advisory Committee are: Frederick L. Jones, Jr., M.D., chairman; Robert L. Mayock, M.D., vice chairman; Rob Roy MacGregor, M.D.; Charles Myers, M.D.; Frederick L. Ruben, M.D.; John Schaaf, M.D.; Edward Theurkauf, M.D.; William Anderson, M.D.; G. W. Atkinson, M.D.; J. William Fewell, M.D.; Sukhdev S. Grover, M.D.; and Robert F. Johnston, M.D.

Evan D. Riehl, M.D., Director
Division of Chronic Respiratory Diseases
Pennsylvania Department of Health

VD education still needed

Incidence of venereal disease in Pennsylvania declined for the third consecutive year in 1977, according to the State Health Department, but statistics show that 60 percent of those infected in 1977 were teenagers and young adults.

Statistics indicate that 30 percent of gonorrhea patients were under 19 years old, and 68 percent were under 24. Sixty percent of those with infectious syphilis were under 30 years.

An effort is being made by the Health Department to educate young people about the dangers of VD. A free VD Info Kit including separate brochures for men and women, information on herpes simplex virus, referral and treatment information, and a new brochure on common sexually transmitted diseases is available to Pennsylvania residents.

For information and referral services and the free VD Info Kit call the toll-free State Health Line, (800) 692-7254, or write Leonard Bachman, M.D., State Health Secretary, Info Kit, PO Box 90, Harrisburg, PA 17120.

editorials

Carbon paper—what's that?

In recent years technological advances have generated many conveniences which we now take for granted. Snow blowers, automatic dishwashers, and instant cameras are examples of innovations designed to facilitate our "fast" style of living. We have come to rely on these innovations, sometimes at the expense of other people.

Photocopying is an inexpensive, rapid method of producing a replica of anything from a letter to a color photograph. Almost every office has a copier, and down time can cause business to grind to a halt, while carbon paper gathers dust on supply shelves.

Copying has created some problems never dreamed of by its inventors. It is cheaper to reproduce a book than to buy it. Duplicating journals is less expensive than subscribing. A publisher's concern over this situation can hardly be questioned.

When does photocopying become abuse? What portion of a book, if any, can be photocopied before it is determined to be an attempt to avoid purchasing that book?

On January 1, 1978, Public Law 94-553, the new copyright law, the first revision since 1909, became effective. It concerns the reproduction of copyrighted work and attempts, however vaguely, to answer such questions. Many in the scientific community feared that the new law would prevent the sharing of information, but close study indicates this is not the case.

The thrust of the revisions has been in two areas. First, the period of coverage by copyright has been extended to include the lifetime of the author plus 50 years. Second, the amount of material protected by copyright has been broadened to include audiovisuals and a variety of other works of art. The law grants certain rights to authors but places limits on these rights. It is ambiguous, sometimes inconsistent, and doubtless will be tested in the courts.

Since the new law is a compromise, none of those affected by it will be completely happy, although it attempts to be fair to authors, publishers, and librarians. Section 108 (i) calls for a report to Congress from the parties involved at five-year intervals. Congress will then determine whether the balance intended by the law is being achieved.

It is in your interest to know about the new copyright law. Keep in mind that authors and publishers depend upon royalties and sales to subsist. Carefully assess your needs. John Shaw Billings wrote, "Statistics are somewhat like old medical journals, or like revolvers in newly opened mining districts. Most men rarely use them, and find it troublesome to preserve them so as to have them easy of access; but when they do want them, they want them badly." The days of unlimited photocopies are over. Be sure when you ask for a reprint that you need it "badly."

David A. Smith, M.D.
Medical Editor

correspondence

Physician's assistant here to stay

To the editor:

The opinion of Dr. Sam Faris (PENNSYLVANIA MEDICINE, December 1977) seems to be asking for comment. As one of those who have embraced the physician's assistant concept, to great benefit of my patients and to great personal satisfaction, I feel that I might be qualified to respond.

I heartily agree with Dr. Faris that Mr. Califano appears to be a declared antagonist of the American practicing physician. Actually, the secretary's statements are quite inflammatory. Maybe just for that reason they should not be taken at face value. After all, it is the state in which we practice that has provided by law the "hammerlock that doctors have" not only on paramedicals but on the entire health system. This hammerlock is named "the license to practice medicine." This license is instituted by law in order to protect the public from unscrupulous and unqualified practitioners. Therefore, a reasonable analysis would seem to indicate that Mr. Califano was ill-advised in making such a statement.

If we would pay attention to the "hammerlock" that other professionals, such as lawyers (and judges), have on the services which they provide, then the reasonable promptness and fairly good quality of medical care would stand in favorable distinction to the endless delays in our present court dockets.

Dr. Faris expresses concern for the 40-year-old physician's assistant whose physician mentor retires or dies. I have often expressed a similar concern for mediocrity and failure. However, the physician's assistant is here to stay and it is up to us, those with the "hammerlock," those who are personally responsible for the welfare of our patients, to see that their services are put to the best use.

What happens to Dr. Faris's faithful office nurse when he retires? Does she become a house painter, orderly, or insurance salesman? Of course not. Most likely she will retire or find another physician or institution with whom she can find employment.

I agree with Dr. Faris that we should carefully guard against an injudicious oversupply resulting from the production of an unnecessarily large number of physician's assistants. If it were left to the physician's conscience to determine whether his practice and his patients need a physician's assistant, that would probably be an adequate safeguard. When the government, federal or state, begins to interfere (and probably rightly so in some instances) we must become much more careful.

What is the place of the physician's assistant in the entire spectrum of "provision of health care?" We are all working together for one goal, which is the benefit of our patients. When we lose sight of that goal because of concern for our own incomes or for government interventions or for other extraneous influences, it is the patient who eventually is the victim. In the process, the physician also loses. Therefore, we must begin to recognize that a physician's assistant is a valuable member of the health team, providing health care in an alternate fashion.

Many medical tasks and specialized functions have been delegated by physicians to special nurses. With proper guidance and instruction they all provide valuable contributions. I cannot believe that an abundant supply of additional physicians in the next decade will displace these professionals, so that their "wares" will be "less desirable."

It behooves the medical profession, organized and working together, to properly define the place of the physician's assistant in the entire spectrum of medical and other health services. It behooves the physician to see that this service by the physician's assistant does not become mediocre, that it does not fail, that it always serves the ultimate benefit of the patient. If we physicians, as a group, define such a concept, the legal formulations will follow.

Jan R. J. deVries, M.D.
Boswell

Corrects record on informed consent

To the editor:

In the February 1978 issue of PENNSYLVANIA MEDICINE, Robert W. Allen, M.D., feeling the frustration of many of our colleagues in dealing with informed consent, suggested that informed consent should be standardized so that the standard as established by physicians could be introduced as evidence in the event of a law suit by a plaintiff alleging that he had not been properly informed.

As the basis for his proposal, Dr. Allen states: "Three points of the informed consent law are: (1) you must warn your patients of all risks that a reasonable man would want to know; (2) in each malpractice case, the jury must decide what a reasonable man would want to know; and (3) to assist the jury in deciding what a reasonable man would want to know, expert testimony can be given as to the standard of medical practice."

While the first two elements are stated correctly, the third is not part of the informed consent law in Pennsylvania. In fact, such testimony may not be introduced by the defendant-physician. In jurisdictions in which an action based on lack of informed consent is treated as any negligence action, the standard of medical practice of the defendant's peers may be introduced by expert witness testimony to aid the jury in its deliberation of whether the defendant's actions have deviated from that standard.

Pennsylvania, as well as a number of other jurisdictions, has rejected this approach to actions based on lack of informed consent. These courts stress that the law, not the physicians, will determine the scope of disclosure, and they do not permit expert witness testimony to be presented to the jury to help in its deliberation. While this treatment of informed consent actions started as common (judge-made) law, it has been incorporated into Pennsylvania Act 111.

In order to make Dr. Allen's approach workable, there must first be an amendment to Act 111 rewording the section pertaining to informed consent, so that a standard of disclosure established by physicians may be presented to a jury.

Jerry Zaslow, M.D., J.D.
Elkins Park

Senator responds to PMS comments

To the Pennsylvania Medical Society:

Thank you for sending me a copy of the Pennsylvania Medical Society's comments to the Health Resources Administration regarding the proposed National Guidelines for Health Planning. It is important that PMS has participated in the rule-making process by letting its concerns be known. I, too, have been concerned about the possible impact of these guidelines on a variety of Pennsylvania hospitals and on the quality and accessibility of health care for the people of our state.

Thank you again for keeping me informed on this important issue; your efforts are most appreciated.

H. John Heinz III
United States Senate

"In a major study just completed in Canada, aspirin reduced the chances of stroke in high-risk men—but not in women...A Harvard neurologist urges anticoagulants for patients with atrial fibrillation...Coal strike drives MDs from Appalachia...A mysterious ailment affecting people who live in mobile homes has been traced to formaldehyde used in construction...A University of Wisconsin psychiatrist reports on the effectiveness of jogging for the treatment of depression..."

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MDs in the news

John M. Donnelly, II, M.D., assistant to the president for medical affairs at the Horsham Clinic in Ambler, has been appointed a medical consultant to the State Board of Medical Education and Licensure. Dr. Donnelly will assist in performing psychiatric evaluations of impaired physicians.

Marvin N. Kallish, M.D., was recently elected president of the medical staff of Episcopal Hospital, Philadelphia. He is director of the department of orthopedics at Episcopal. **Karl A. Giulian, M.D.,** director of the department of obstetrics and gynecology at Episcopal, was elected vice president. **Louis H. Castor, M.D.,** is the new secretary-treasurer.

John Hall, Jr., M.D., professor of surgery and director of the trauma unit at Temple University School of Medicine, has been elected chairman of the board of directors of the Philadelphia County Professional Standards Review Organization, which reviews care in the county's 39 acute care hospitals. Other new officers of the PSRO include: **Avery W. Beverly, M.D.,** vice chairman; **Jonathan E. Rhodes, Sr., M.D.,** president; and **George R. Fisher, M.D.,** secretary.

Lawrence Temeles, M.D., Philadelphia, has been elected president of the medical staff of Philadelphia Psychiatric Center. Also elected are: **Arnold D. Goldman, M.D.,** vice president; **David M. Ellis, M.D.,** secretary-treasurer; and **Joan Gross, M.D.,** and **Herbert M. Adler, M.D.,** members of the executive board.

Herbert S. Heineman, M.D., of West Mount Airy, has been appointed chairman of the infection control committee and director of the microbiology laboratory at Mercy Catholic Medical Center, Darby. Dr. Heineman is on the faculty of Hahnemann Medical College and Hospital, where he was formerly director of the division of infectious diseases.

Elmo J. Lilli, M.D., has been elected chief of staff of Pocono Hospital, East Stroudsburg. Dr. Lilli, a family practitioner, is chairman of the Sub-Area Health Systems Council of Eastern Pennsylvania. Other officers elected for one-year terms are: **Robert F. G. deQuevedo, M.D.,** an obstetrician/gynecologist, vice chief of staff; and **Mark Pliskin, M.D.,** a radiologist, secretary-treasurer.

Loren H. Roth, M.D., recently was promoted to the rank of associate professor of psychiatry at the University of Pittsburgh School of Medicine. Dr. Roth also is director of the Law and Psychiatry Program at the school and the editor of the newsletter for the American Academy of Psychiatry and Law.

The Berks County Medical Society recently honored three of its members who have served the medical profession for 50 years. They are: **Thomas Butterworth, M.D.,** Reading; **Albert E. J. Lohmann, M.D.,** also of Reading; and **Harold L. Strause, Sr., M.D.,** of Greenfields.

Isadore Brodsky, M.D., chairman of the department of medical oncology and hematology at Hahnemann Medical College and Hospital, recently was named the first occupant of the Herbert L. Orlowitz Chair in Medical Oncology and Hematology. The newly founded Herbert L. Orlowitz Institute is dedicated to the study and treatment of cancer and diseases of the blood.

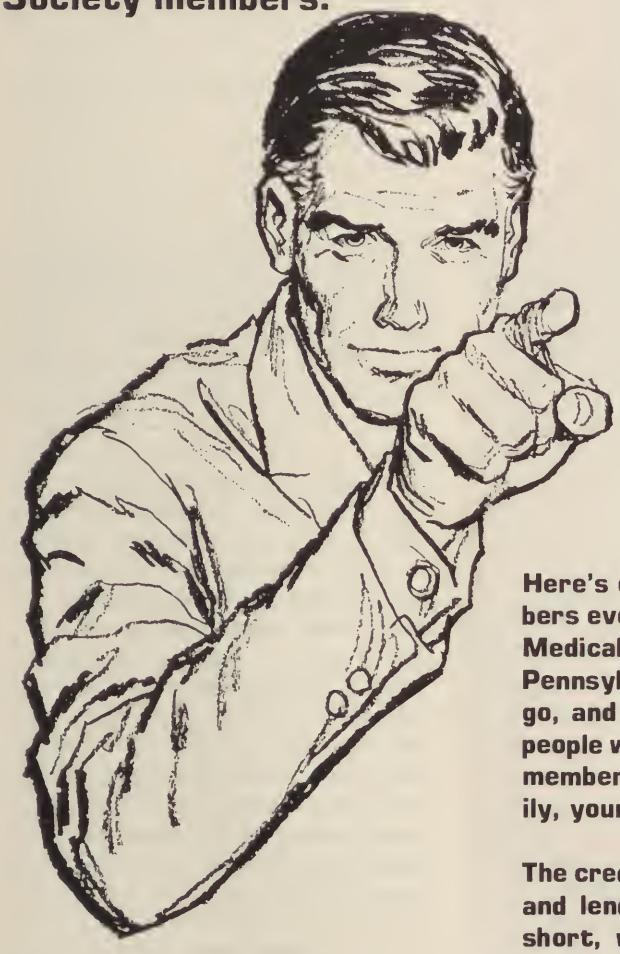
Sarah S. Long, M.D., assistant professor of pediatrics at Temple University School of Medicine, has won the 1977 Russell P. Moses Award for outstanding clinical teaching at the university. In 1976 Dr. Long received the "Golden Apple" award for her teaching ability from the Temple Chapter of the American Medical Students Association.

Richard G. Lonsdorf, M.D., associate professor of psychiatry and law at the University of Pennsylvania School of Law, has been elected president of the Mental Health Association of Southeastern Pennsylvania for 1978.



PHYSICIANS in the Valley Medical Group, Shippensburg, have found a solution to the energy problems presented by Pennsylvania winters. ***Albert W. Freeman, M.D.,*** *son* ***William A. Freeman, M.D.*** *(both above), and* ***John W. Breneman, M.D.,*** *installed a 2,000 square foot collector frame that converts the sun's rays into solar heat for their medical offices. The system was put to work nearly a year ago and thus far, despite a few snags, has proven its value as a cost and energy saver.*

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High blood pressure attack mounted in Pennsylvania

William C. Spring, Jr., M.D.
Robert A. Ranberg

In the past decade, profound changes have occurred in the medical management of hypertension which, with its related diseases and complications, accounts for about one-half of all deaths occurring annually in Pennsylvania. Not since the advent of antibiotics has there been such an opportunity for physicians, nurses, and other health care professionals to participate actively in controlling this health problem.

Traditionally physicians have been trained to treat the sick based on their complaints, symptoms, and physical signs. The therapy prescribed usually controls the illness with prompt amelioration and eventual recovery. The management of hypertension, however, is different.

Hypertension is a symptomless illness which may silently damage the victim's body. How can practitioners be helped to recognize that of all their hypertensive patients, as many as half will be free of the symptoms or complications of hypertension, but if untreated will continue to die prematurely of diseases stemming from it?

This and subsequent articles will provide background and information necessary for a coordinated statewide attack on hypertension by professionals and the public.

Where we've been

Effective management of essential hypertension began with the introduction of the thiazides more than a quarter of a century ago. But it was the landmark studies of the Veterans' Administration Cooperative Study Group on Antihypertensive Agents under the chairmanship of Dr. Edward B. Freis that provided conclusive evidence, at least in males, of the effectiveness of such treatment programs.[1,2]

In 1972 the Secretary of Health, Education, and Welfare launched the National High Blood Pressure Education Program, coordinated by the National Heart, Lung, and Blood Institute and involving other federal agencies, virtually all state health departments, and more than 150 private sector organizations.

In Pennsylvania a Governor's Task Force on Hypertension was formed in 1974. Its 1975 report proposed "to attack the problem of disability and death from stroke and cardiovascular disease secondary to high blood pressure through a program of educational activities designed to modify the behavior of consumers and providers of health services."[3]

During this same period, the Council on Education and Science of the Pennsylvania Medical Society recognized the need to coordinate the activities of the many agencies involved and asked John H. Moyer, M.D., of Johnstown, to develop a Hypertension Coordinating Committee. This committee served an important interim coordinating function.

In addition to the educational and public information activities at the national and state levels, the American Heart Association, the Health Department, and other organizations have conducted screening programs each May in support of National High Blood Pressure Month. Further campaigns throughout the year have resulted in the establishment of many permanent screening sites.

The effect of this national education program is evident. Two national surveys taken more than a decade apart reflect considerable improvement in awareness of and adequate therapy for hypertensives. Between 1960 and 1962, nearly 44 percent of hypertensives were unaware of their condition; this figure had diminished to 29 percent when resurveyed in 1973-74.[4] While only 15 percent of hypertensives in the earlier survey received adequate therapy, more recent data indicate that this figure has increased to 29 percent. The message is getting through, but we still have a long way to go: more than 70 percent of hypertensives still don't receive adequate care!

Where we are

In August of 1976 the Pennsylvania Department of Health contracted with the American Heart Association, Pennsylvania Affiliate, to cooperate in an effort to organize a hypertension control program. The program was launched officially on September 23, 1977 when Leonard Bachman, M.D., Secretary of Health for the Commonwealth, and Lawrence N. Adler, M.D., president of the American Heart Association, Pennsylvania Affiliate, jointly announced their goals.[5] A Pennsylvania High Blood Pressure Control Advisory Committee, consisting of many agencies, has been organized. The first chairman is Arthur R. Taylor, M.D., Williamsport, representing the Pennsylvania Academy of Family Physicians; vice chairman is J. Edwin Wood, III, M.D., Philadelphia, chairman of the Task Force on High Blood Pressure of the American Heart

This article is the first in a series on hypertension and the control program of the Pennsylvania Department of Health and the American Heart Association, Pennsylvania Affiliate. Dr. Spring is chief of the High Blood Pressure Control Program of the Pennsylvania Department of Health, and Mr. Ranberg is director of the Division of Chronic Diseases, Pennsylvania Department of Health.

Association, Pennsylvania Affiliate.

High on the Council's agenda is the development of programs of professional and public education. The screening program conforms to the basic guidelines of the Moser Report,[6] which has been sent to most Pennsylvania physicians who manage hypertensives.

A 1978 goal has been set to screen 200,000 persons. A key feature of the program is a uniform data system for all screening centers. The system is computerized centrally and contains confidentiality safeguards. Screening steps include a visit to a primary site, and persons with blood pressure elevation may choose to be referred to their private physician or to a secondary site.

Where we're going

Where do we go from here? Our goals may be stated simply:

1. Identify existing hypertensives
2. Refer for appropriate treatment and follow-up
3. Review periodically such guidelines as blood pressure levels and treatment regimens in keeping with generally accepted scientific experience

A statement of goals is important, but it's never enough. Detection and management of hypertension requires the concerted efforts of health care professionals, administrators, and laymen. It is hoped that the Pennsylvania High Blood Pressure Control Program will bring together these groups in a statewide attack on hypertension. □

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Behavior therapy in primary care practice

Tjiauw-Ling Tan, M.D.
Michael Pertschuk, M.D.

Behavior therapy attempts to alleviate specific behavioral problems by systematically altering the patient's learned behavior. While traditional psychodynamic therapies attempt to resolve symptoms by understanding their psychological origins, behavior therapy focuses directly on the symptom itself. Studies have shown that when the application of behavior therapy is successful, new symptoms are not likely to be substituted for the original ones. In fact, modification of symptoms may result in improvements in other areas of the patient's life.

Clinical aspects

Behavior therapy begins with a comprehensive analysis designed to identify the initial problem and related factors. This analysis is based as much as possible on observation of the patient's behavior as it occurs naturally. The observer may be the physician, a friend or relative of the patient, or the patient himself.

It is important to evaluate the patient's attitudes toward his everyday activities and his physiological reactions to them. He should report any anxiety, fear, guilt or worry, and note the effects of these symptoms on his interactions with others. Does he become withdrawn, abusive, or overly compliant to members of his family? Behaviors such as overeating, stuttering, or aggressive outbursts are noted. It is also helpful to determine the conditions that enable the patient to control or relinquish his undesirable behavior.

"ABCs" of behavior change

In behavioral analysis, the patient's individuality is explicitly recognized and subsequent therapy is tailored to the individual. However, the physician uses general principles of conditioning and learning theory as well as his observations of previous patients and their interaction with various environments, such as hospital, clinic, and home.

Human behavior can be modified or controlled at three principal levels, sometimes described as the "ABCs" of behavior change: (A) the antecedent of the behavior, (B) the behavior itself, and (C) the consequences of the behavior.

First, behavior can be modified by changing the specific conditions which precipitate the behavior. Second, the type of behavior that occurs in a particular situation can be changed or modified. Third, the consequences of the undesired behavior can be altered, thus modifying future behavior. The techniques of behavior therapy described below may be used in treating conditions commonly seen by the physician in primary care practice.

Modifying antecedents

Stimulus control analysis—It is common for a patient to complain of a specific problem, such as overeating, smoking or hyperventilation caused by anxiety, without being able to describe the circumstances that provoke the behavior. Even when the patient feels he understands what precipitates the unwanted behavior, he usually cannot recall accurately the specific details.

To help the patient recognize the cues or stimuli that trigger the problem behavior, the physician asks the patient to keep a detailed record of the behavior. For example, if the patient complains of recurrent panic attacks, the physician might request the patient to write down the time each attack occurred, where it took place, who was present, the patient's emotional state before the attack, and the intensity of the episode.

When kept on a daily basis, this log provides the detail needed to describe behavioral patterns, and guides the physician in choosing additional interventions to alter antecedents of problem behavior.

Relaxation training—Relaxation training teaches the patient to relax systematically the muscle groups of the body, resulting in a lowered level of physiological arousal and a feeling of calmness. Patients with tension, anxiety, or phobias benefit from this training because it is based on the principle that relaxation is antagonistic to anxiety.

The patient is asked to tense voluntarily the individual muscle groups, beginning with the forearm. Muscles then are relaxed gradually while the patient breathes slowly and deeply. Instructions, such as "All tension is leaving your arm; you are feeling very good, very relaxed," are given. Other muscle groups are systematically tensed and relaxed in the same manner.

Imagery may be added to the exercises by asking the patient to fantasize a pleasant, calm scene. Practiced by the patient two or three times a day and as needed at home, relaxation training often attenuates feelings of tension.

Systematic desensitization—A modified combination of the two techniques described is termed systematic desensitization. The patient practices muscle relaxation and keeps a detailed behavioral log. The log is expanded to include the patient's rating of the situations that provoke his anxiety according to the degree of anxiety

Dr. Tan is director of the behavior therapy clinic in the department of psychiatry at The Pennsylvania State University College of Medicine, Hershey. Dr. Pertschuk is associate director of the center for behavioral medicine at the University of Pennsylvania School of Medicine, Philadelphia.

induced. The physician then rates the severity of the patient's anxiety-arousing situations.

When the patient is relaxed, the physician asks him to imagine the lowest ranked anxiety-provoking situation. With repetition of this imagery, the anxiety progressively diminishes. Once the patient is comfortable with the lowest anxiety situation, the physician moves to the next item. When discomfort is expressed with any imagined situation, the patient is instructed to relax, and the scene is repeated until the patient is able to relax while imagining it. Through this technique, the patient learns to transfer the psychophysiologic responses which accompany relaxation to the real life situations which induced anxiety.

Reinforced practice—Reinforced practice, or "*in vivo* desensitization," requires the use of actual objects and situations to help the patient overcome irrational and unadaptive fears. The patient may be exposed gradually to the situation that produced fear, at the same time utilizing the learned response of relaxation. In the treatment of a phobia of cats, spiders, or other small objects, the confined object may gradually be brought closer to the patient as tolerated. In treating a fear of driving, the patient may first imagine driving while only looking at the automobile, then while sitting at the wheel while the car is parked, then while the motor is started, etc.

Because the patient confronts the fear-eliciting situation with the encouragement of the physician and the concomitant use of relaxation exercises, this procedure eliminates the problem of generalizing to the actual feared situation when using desensitization with imagery.

Modifying behavior

Shaping—The shaping procedure helps a patient to build new behaviors by rewarding successively greater approximations of the desired behavior. The technique was first used to treat autistic children. The children, who were unable to talk, were rewarded with food for simply looking at the therapist. Once this behavior was maintained, the reward was given for lip movement and then for vocalization.

This approach requires that the physician identify a target behavior and construct a system of rewards for behaviors already manifested that are related to the target desired. Each increment to this behavior is rewarded until the target behavior finally is achieved.

The primary care physician can apply the principles of the shaping technique when counseling parents about toilet training procedures or about building a child's self-help skills, particularly in the case of the retarded or handicapped child. It is also useful when counseling parents who are in conflict with a resistive child who does not cooperate in various age-appropriate routines.

Modeling—It is sometimes possible for a physician to avoid the often painstaking procedure of shaping by simply modeling (for observational learning) the desired behavior. For example, when an obese patient feels at a loss for a polite way to refuse offered food, the physician can model responses for the patient's future use.

Modeling also has been used in treating phobias. By observing the physician or another individual successfully engaged in a situation that would be fear-provoking to the patient, he may be able to diminish his anxiety.

Role playing—In role playing, or behavior rehearsal, the physician assumes the roles of significant persons (boss, spouse, employe, or parent) in the patient's life and enacts with the patient a series of scenes that typify a problem situation. During these scenes, the patient's verbal content, mode of expression, tone of voice, inflection, and resonance are noted by the physician. The patient receives feedback in order to become aware of and remove apologetic hesitations or quarrelsome overtones. Nonverbal behavior, such as posture, gait, eye contact, and facial expression, is also modified.

The role-playing technique, combined with shaping and modeling procedures, has become popular as "assertiveness training." It enables individuals to develop their social responses, both positive and negative, to more adaptive and satisfactory levels.

Negative practice—The negative practice treatment method, sometimes used for the control of involuntary motor habits, such as nailbiting, tics or stuttering, extinguishes a habit through exhaustive repetition. The patient is instructed to practice the unwanted behavior to the point of fatigue. Although the mechanism behind this approach is not understood, the purposeful repetition of unwanted behavior enables the patient to bring that behavior under conscious control.

Biofeedback—The biofeedback procedure has been most successful in treatment of psychophysiologic problems, including tension and migraine headaches, torticollis, and bruxism. There also have been positive reports of its use in treating asthma and epilepsy. It is generally not used in a private practice setting, however, because special equipment is needed.

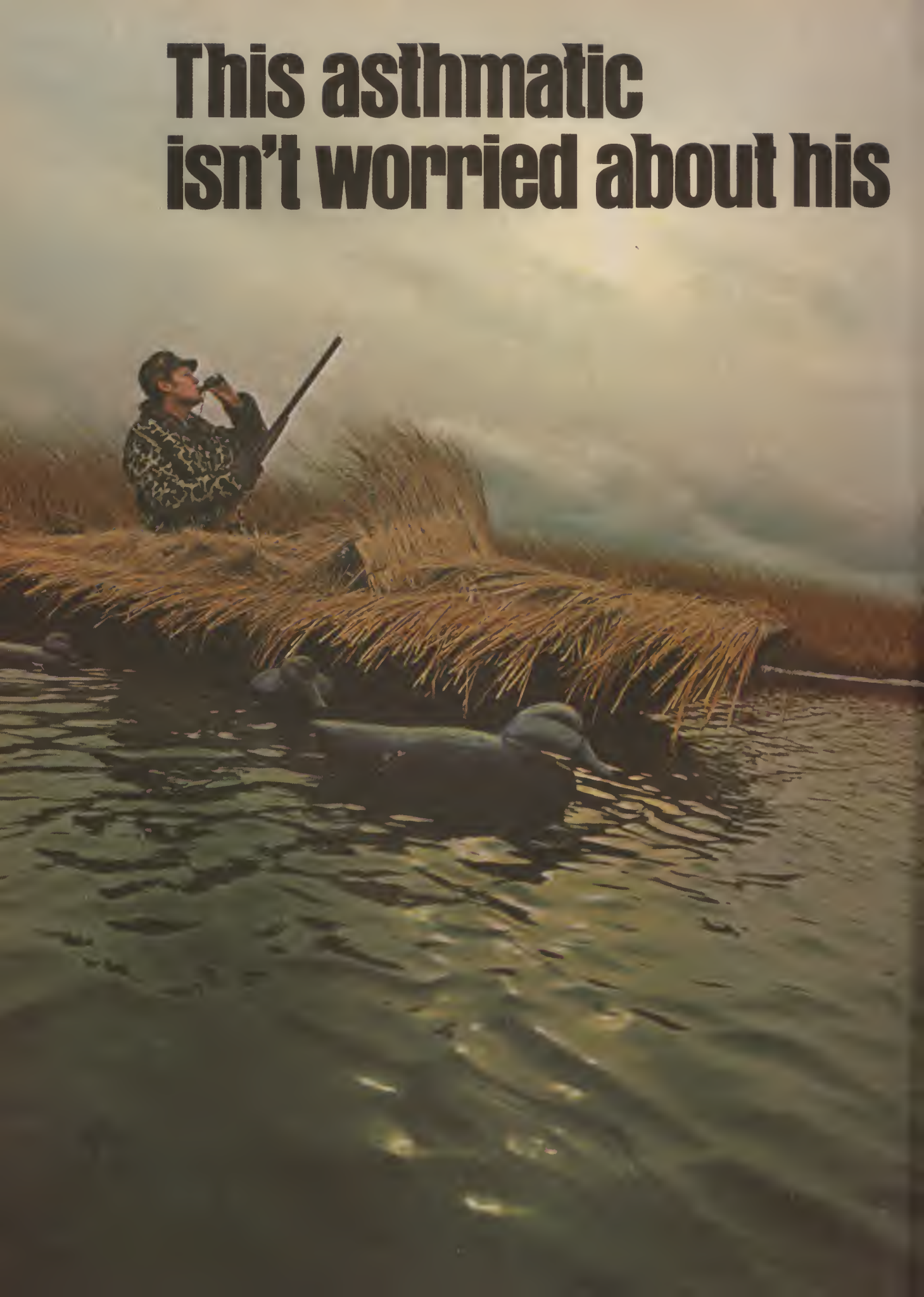
In biofeedback, information on physiologic activity about which the patient is not normally aware is fed back to him via electronic instrumen-

Continued on page 56.

This is the sixth in a series of articles on office counseling for the primary care physician prepared by the departments of psychiatry of the medical schools in the Commonwealth.


COLACE prevents hard, dry stools common to constipation . . . and does it without laxative stimulation. COLACE assists peristalsis by simply letting intestinal water permeate stools.
COLACE helps to prevent painful straining at stool—particularly important in patients with delicate anorectal disorders. Safe and non-habit forming . . . COLACE, the simple water way to ease constipation from infancy to old age.
Simple drops of water help make COLACE® the most widely used stool softener.
COLACE®
dioctyl sodium sulfosuccinate
Mead Johnson
PHARMACEUTICAL DIVISION

This asthmatic isn't worried about his



next breath...

he's active
he's effectively
maintained on

QUIBRON®

Each capsule or tablespoonful (15 ml) elixir contains theophylline (anhydrous) 150 mg and glyceryl guaiacolate (guaifenesin) 90 mg. Elixir: alcohol 15%

high theophylline for effective around-the-clock therapy

Quibron may give the asthmatic up to eight hours of bronchodilation with each dose and provides the high dosages of theophylline which are now believed necessary to keep patients free of acute attacks and chronic wheezing.

100% free theophylline

Quibron helps achieve high serum theophylline levels with minimal dosage volume...delivers 100% free theophylline in comparison to many other compounds which contain from 47% to 91% effective theophylline.

individualized theophylline dosage schedule

Today's more efficient usage of theophylline includes individualizing dosage and monitoring serum theophylline levels. The usual recommended dosages of Quibron are: Adults—1 to 2 capsules or tablespoonfuls every 6 to 8 hours; dosage may be cautiously adjusted upward when necessary to a maximum of 2000 mg theophylline per 24 hours. Children under 12—4 to 6 mg theophylline per kg/body weight every 6 to 8 hours; dosage may be cautiously adjusted up to 9 or 10 mg/kg every 6 hours.

Now, for the asthmatic who requires high-dose theophylline therapy for therapeutic serum concentrations

Mead Johnson Pharmaceutical Division announces

QUIBRON®-300

Each capsule contains 300 mg theophylline (anhydraus) and 180 mg glyceryl guaiacalate (guaifenesin)

For Brief Summary, please see the last page of this advertisement.

QUIBRON®-300

Each capsule contains 300 mg theophylline (anhydrous) and 180 mg glyceryl guaiacolate (guaifenesin)

The new high-dose theophylline capsule... for dependable theophylline therapy when products of lower dosage do not adequately control asthma symptoms.

Specially formulated

...for optimal efficacy

Quibron-300 is appropriate therapy for asthma patients whose symptoms are not adequately controlled on lower doses of theophylline, particularly for patients whose theophylline dosage has been adjusted upward to achieve therapeutic serum levels. In one study,[1] an average peak increase in FEV_1 of 35% was demonstrated after a single dose equivalent to one Quibron-300 capsule, and significant improvement in this pulmonary function lasted for nearly eight hours after administration.

...for optimal predictability

One Quibron-300 capsule q6-8h yields therapeutic serum levels (10-20 mcg/ml) in many adults. With a single dose, more than 75% of patients achieved serum levels potentially providing clinical benefit (5-15 mcg/ml). Half-life of theophylline varies widely from patient to patient, making monitoring of theophylline therapy important. Patient response may be monitored clinically if blood levels are not available as long as dosage does not exceed 1200 mg in 24 hours for adults.

...for optimal dosage convenience

The simple, convenient dosage of new Quibron-300—one capsule every six to eight hours—makes it easy for patients to comply with high-dose regimens often required to achieve therapeutic serum levels. Quibron-300 capsules may provide maximum therapeutic value with maximum convenience. In fact, the switch from a low-dose to a high-dose regimen may be accomplished by merely switching capsules, by stepping up to Quibron-300 capsules.

...for minimal theophylline side effects

Adverse reactions to theophylline are related to serum levels and are usually not a problem at concentrations below 20 mcg/ml. Of 45 patients studied[1] after a single dose, only seven reported adverse reactions. The most common reaction was a feeling of lightheadedness by three of these seven patients.

Reference 1. Data on file, Mead Johnson Pharmaceutical Division.

Indications: For the symptomatic treatment of bronchospastic conditions such as bronchial asthma, asthmatic bronchitis, chronic bronchitis, and pulmonary emphysema.

Dosage: Quibron—Adults: 1-2 capsules or 1-2 tablespoonfuls elixir every 6-8 hours. Children under 12: 4-6 mg theophylline/kg body weight every 6-8 hours.

Quibron-300— Adults: 1 capsule every 6-8 hours.

Theophylline dosage may be cautiously increased to 2000 mg/24 hour in adults and 9 or 10 mg/kg every 6 hours in children. Monitoring of serum theophylline levels at higher dosages is recommended.

Precautions: Do not administer more frequently than every 6 hours, or within 12 hours after rectal dose of any preparation containing theophylline or aminophylline. Do not give other xanthine derivatives concurrently. Use in case of pregnancy only when clearly needed.

Adverse Reactions: Theophylline may exert some stimulating effect on the central nervous system. Its administration may cause local irritation of the gastric mucosa, with possible gastric discomfort, nausea, and vomiting. The frequency of adverse reactions is related to the serum theophylline level and is not usually a problem at serum theophylline levels below 20 μg/ml.

How Supplied: Quibron Elixir: Bottles of 1 pint and 1 gallon. Quibron Capsules: Bottles of 100 and 1000 and unit-dose packs of 100. Quibron-300 Capsules: Bottles of 100.

Mead Johnson PHARMACEUTICAL DIVISION

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MJL 7-4280



Tolinase®
tolazamide, Upjohn

Please contact your Upjohn representative for additional product information.

Upjohn

J-5695-6

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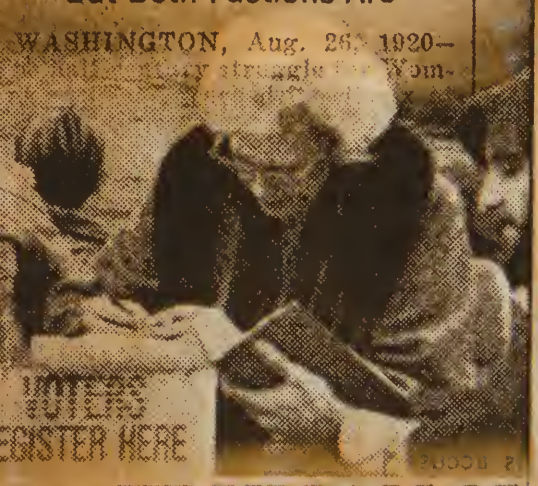
COLBY PROCLAIMS WOMAN SUFFRAGE

Signs Certificate of Ratification at His Home Without Women Witnesses.

MILITANTS VEXED AT PRIVACY.

Wanted Movies of Ceremony, But Both Factions Are

WASHINGTON, Aug. 26, 1920—



Social Security Bill Is Signed; Gives Pensions to Aged, Jobl

Roosevelt Approves Message Intended to Benefit 30,00 Persons When States Adopt Cooperating Laws–He C the Measure 'Cornerstone' of His Economic Progra

WASHINGTON, Aug. 14, The Social Security Bill, pro a broad program of unemplo insurance and old age pe and counted upon to benefi 20,000,000 persons, became l day when it was signed by dent Roosevelt in the prese those chiefly responsible fo ting it through Co s.

Mr. Roosevelt cal the m "the cornerstone st whi is being h me s comple ri o p

SENATE APPROVES 18-YEAR OLD VOTE IN ALL ELECTIONS

Amendment to Constitution is Sent to House, Where Passage is Expected

WASHINGTON, March 10, 1971—The Senate approved today 94 to 0 and sen o

TRUMAN CLOSES TED NATIONS CONFEREN ITH PLEA TO TRANSLATE CHARTER INTO DEEDS

NEW WORLD HOPE

President Hails 'Great Instrument of Peace,' Insists It Be Used

HISTORIC LANDMARK

Meeting Gives Standing Ovation as Executive Pictures Peace Gain

"If we fail to use it," he declared to the solemn final meeting of the delegates, 'we shall betray all of those who have died in order that we might meet here in freedom and safety to create it.'

"If we seek to use it selfishly—for the advantage of any one nation or any small group of nations—we shall be equally guilty of that betrayal."

Fervent Interpolation

The President, speaking in the auditorium of the War Memorial Opera House, built in memory of sons of the Golden Gate city who gave their lives in the first World War, in which he himself served, seemed to give unconscious expression to the solemn feeling of the occasion when, at the outset of his speech, he interpolated the words, half a hope, half a prayer:

"Oh, what a great day this can be in history!"

Just before the plenary session

SIGNE the Draf Ends No

WASHINGTON, Jan. 27, 1973—"With the signing of the peace agreement in Paris today, and after receiving a report from the



PATIENT PACKAGE INSERTS: A CONCEPT WHOSE TIME HAS COME?

The consumer's right to know is an irreversible and desirable trend of the Seventies. It extends, and properly, to a patient's right to know more about his or her prescription medications. One way, gaining favor, is through patient package inserts. Wisely-prepared and properly distributed when medically indicated, they could markedly improve patient knowledge and drug therapy—laudable goals by anyone's standards.

The PMA endorses these goals and will work with government, the health professions and consumers to achieve them.

The Advantages

The concept holds promise of benefits: better patient understanding of the product prescribed, better adherence to the treatment plan, and more awareness of possible side reactions.

Every doctor has had patients who fail to finish antibiotic regimens because they feel better. Some patients assume that if one tranquilizer or analgesic is good, two may be twice as good. Still others fail to report dizziness while on antihypertensive therapy —and so on.

Problems like these might arise less often if the patient received written information in addition to verbal instructions. Some studies suggest that patients are more receptive to such materials, and they more often understand the verbal instructions and follow them, when inserts are used.

The Disadvantages

There are also some potential problems. Obviously, the inserts must be clearly phrased, without extraneous or complex detail. How much information is enough? How can it be kept current? Should all patients receive the same information? Should inserts be included with all drugs? Should only potential problems be listed or are patients better off with a "fair balance" presentation that describes usefulness as well as drawbacks?

These and similar questions require answers, since model inserts have yet to be properly developed and tested. Despite the need for these studies, the FDA is proceeding prematurely with inserts on selected products. We think the Congress is the only place where the matter can be given the proper legal status and direction, particularly since it represents a conceptual change in the legal, medical and social framework of the nation's prescription drug information system.

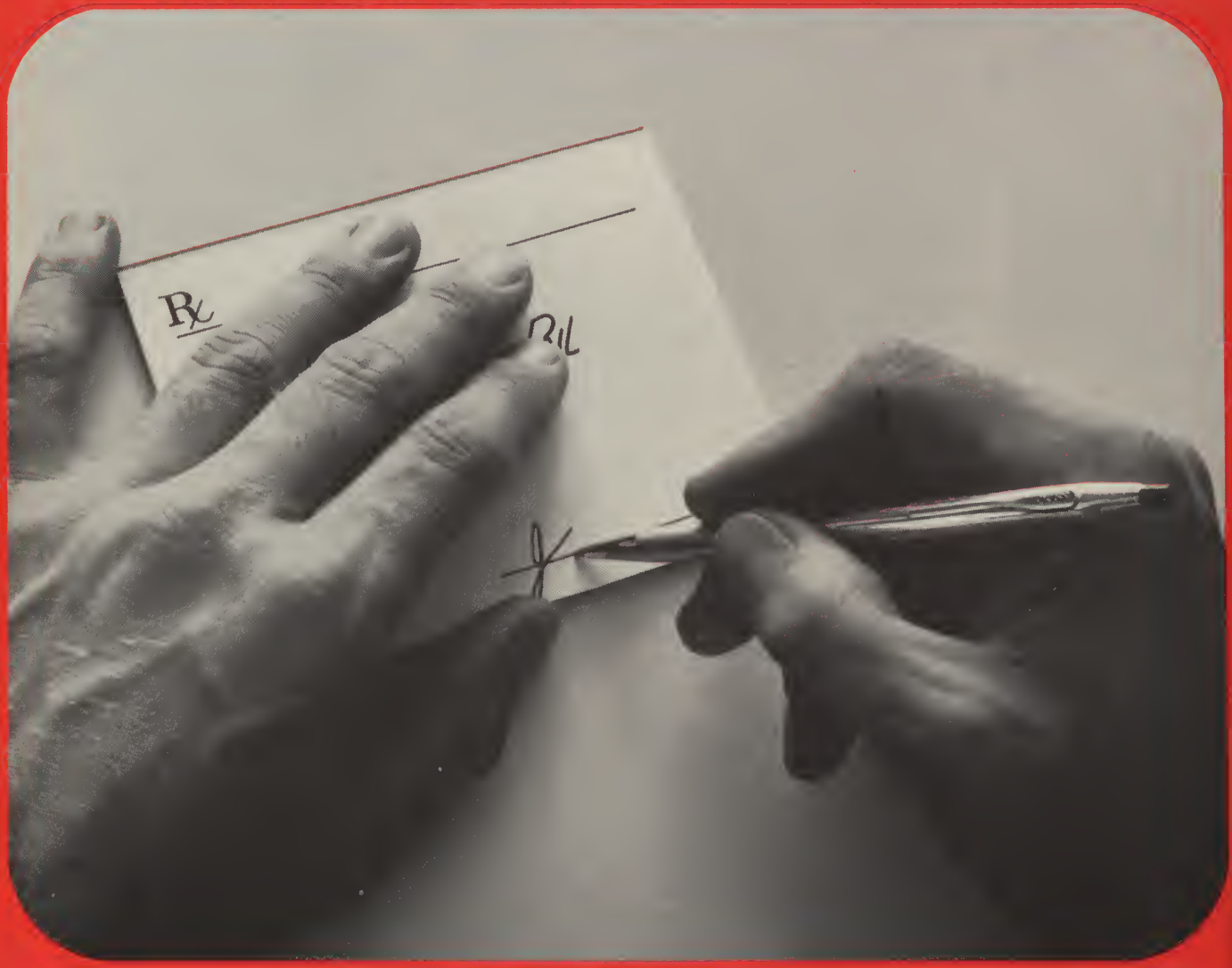
The Solution

The PMA believes that carefully-devised pilot studies of various kinds of inserts are needed. They should be developed and implemented with full participation by doctors, pharmacists, consumers, communications experts and the drug industry. Such studies will provide reliable pathways to follow, so that inserts will be useful aids to medical practice.

And particularly we think that you should be closely involved in this debate and in these studies and decisions. Otherwise, people with less experience and qualifications may control the purposes, content and use of a tool with considerable promise for improved patient care. It could make a difference in your practice tomorrow, and more importantly, in the health of your patients.

PMA
THE PHARMACEUTICAL MANUFACTURERS ASSOCIATION
1155 FIFTEENTH ST., N. W., WASHINGTON, D. C. 20005

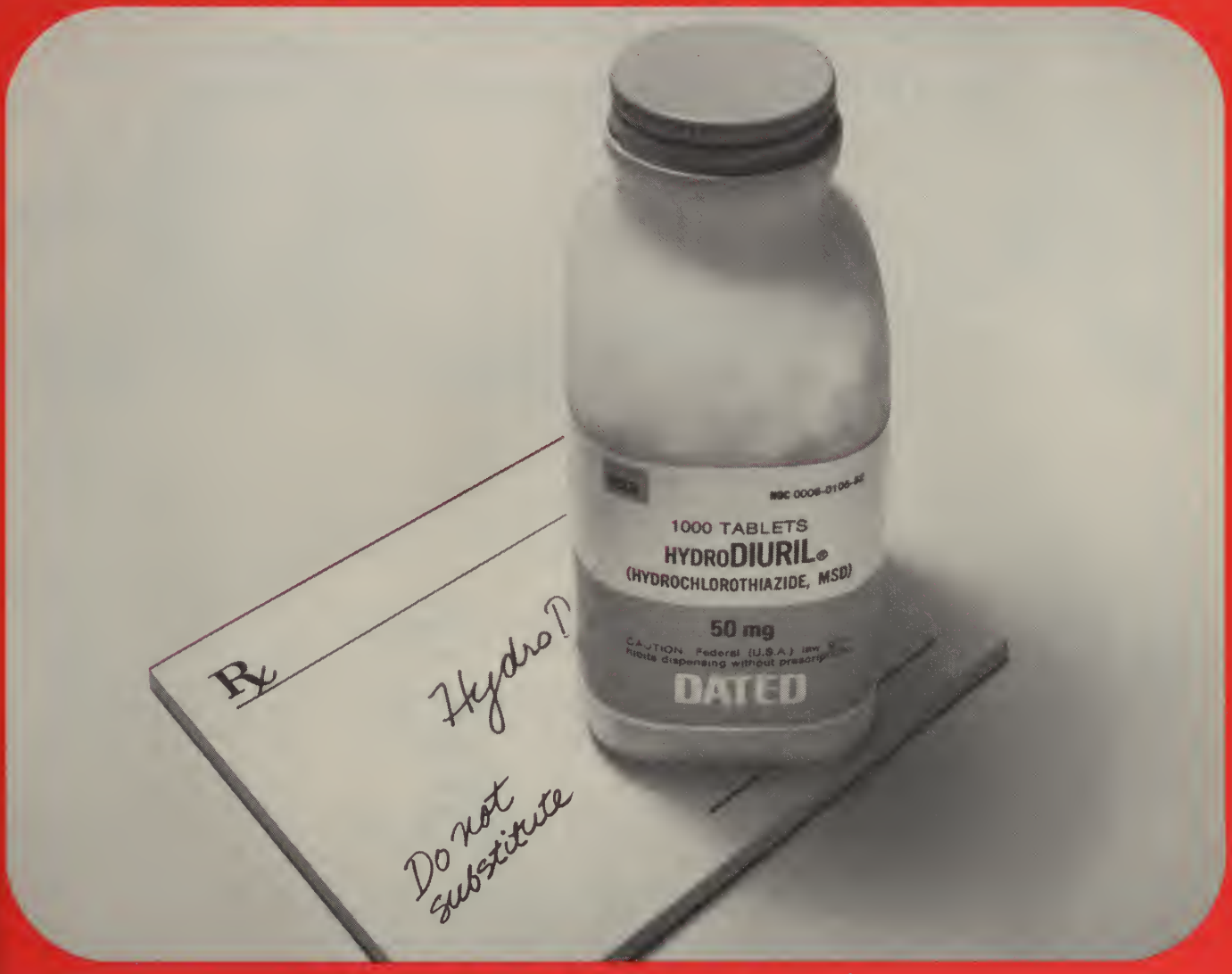
There is no substitute



yours...

Contraindications: Anuria; hypersensitivity to this or other sulfonamide-derived drugs.
Warnings: Use with caution in severe renal disease. In patients with renal disease, thiazides may precipitate azotemia. Cumulative effects may develop in patients with impaired renal function. Use with caution in patients with impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte balance may precipitate hepatic coma. May add to or potentiate action of other antihypertensive drugs; potentiation occurs with ganglionic or peripheral adrenergic blocking drugs. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possibility of exacerbation or activation of systemic lupus erythematosus has been reported. Lithium generally should not be given with diuretics because they reduce its renal clearance and add a high risk of lithium toxicity. Read circulars for lithium preparations before use of such concomitant therapy. *Use in Pregnancy:* Thiazides cross placental barrier and appear in cord blood; in pregnancy, weigh anticipated benefit against possible hazards to fetus, including fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions that have occurred in adults. *Nursing Mothers:* Thiazides appear in breast milk; if use of drug is deemed essential, patient should stop nursing.
Precautions: Perform periodic determination of serum electrolytes to detect possible electrolyte imbalance. Observe all patients for clinical signs of fluid or electrolyte imbalance, namely, hyponatremia, hypochloremic alkalosis, and hypokalemia. Serum and urine electrolyte determinations are particularly important when patient is vomiting excessively or receiving parenteral fluids. Medication such as digitalis may also influence serum electrolytes. Warning signs, irrespective of cause, are dryness of mouth, thirst, weakness, lethargy, drowsiness, restlessness, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbances such as nausea and vomiting. Hypokalemia may develop, especially with brisk diuresis, in severe cirrhosis, with concomitant corticosteroid or ACTH therapy, or with inadequate oral electrolyte intake. Hypokalemia can sensitize or exaggerate response of heart to toxic effects of digitalis (e.g., increased ventricular irritability). Hypokalemia may be avoided or treated by use of potassium supplements, such as foods with a high potassium content. Any chloride deficit is generally mild and usually does not require specific treatment except under extraordinary circumstances (as in liver disease or renal disease). Dilutional hyponatremia may occur in edematous patients in hot weather; appropriate therapy is water restriction, rather than administration of salt except in rare instances when the hyponatremia is life threatening. In actual salt depletion, appropriate replacement is the therapy of choice.
Hyperuricemia may occur or frank gout may be precipitated in certain patients. Insulin requirements in diabetic patients may be increased, decreased, or unchanged; latent diabetes mellitus may become manifest. Thiazides may increase responsiveness to tubocurarine. Antihypertensive effects of the drug may be enhanced in post-sympathectomy patients. May decrease arterial responsiveness to norepinephrine; this diminution is not sufficient to preclude effectiveness of the pressor agent for therapeutic use. If progressive renal im-

for experience—



or ours.

pairment becomes evident, consider withholding or discontinuing diuretic therapy. Thiazides may decrease serum PBI levels without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. Pathologic changes in the parathyroid gland with hypercalcemia and hypophosphatemia have been observed in a few patients on prolonged therapy; thiazides should be discontinued before testing for parathyroid function.

Adverse Reactions: *Gastrointestinal System*—Anorexia; gastric irritation; nausea; vomiting; cramping; diarrhea; constipation; jaundice (intrahepatic cholestatic jaundice); pancreatitis; sialadenitis.
Central Nervous System—Dizziness; vertigo; paresthesias; headache; xanthopsia.
Hematologic—Leukopenia; agranulocytosis; thrombocytopenia; aplastic anemia.
Cardiovascular—Orthostatic hypotension (may be aggravated by alcohol, barbiturates, or narcotics).
Hypersensitivity—Purpura; photosensitivity; rash; urticaria; necrotizing angiitis (vasculitis) (cutaneous vasculitis); fever; respiratory distress including pneumonitis; anaphylactic reactions.
Other—Hyperglycemia; glycosuria; hyperuricemia; muscle spasm; weakness; restlessness; transient blurred vision.
Whenever adverse reactions are moderate or severe, thiazide dosage should be reduced or therapy withdrawn.

Note: When used with other antihypertensive drugs, careful observations for changes in blood pressure must be made, especially during initial therapy. Dosage of other antihypertensive agents must be reduced by at least 50 percent as soon as this drug is added to the regimen. As blood pressure falls under the potentiating effect of this agent, further reduction in dosage, or even discontinuation, of other antihypertensive drugs may be necessary.

How Supplied: Tablets containing 25 mg hydrochlorothiazide each in bottles of 100 and 1000 and single-unit packages of 100; Tablets containing 50 mg hydrochlorothiazide each in bottles of 100, 1000, and 5000 and single-unit packages of 100; Tablets containing 100 mg hydrochlorothiazide each in bottles of 100.

For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486

J6HD04(528)

MSD
MERCK SHARP & DOHME

In hypertension

TABLETS: 25 mg, 50 mg, and 100 mg

HydroDIURIL®

(HYDROCHLOROTHIAZIDE|MSD)

When **impotence** due to androgenic deficiency is driving them apart



Android®-5 Buccal Tabs
Android®-10 Oral Tabs
Android®-25 Oral Tabs

Methyltestosterone U.S.P. – 5, 10, 25 mg.

Additional Indications:
REPLACEMENT THERAPY. When Androgen Deficiency is cause of:

- Male Climacteric
- Eunuchoidism, Eunuchism
- Post-Puberal Cryptorchidism

New Double-Blind Study ANDROID-25 vs. Placebo*

*R. B. Greenblatt, M.D.; R. Witherington, M.D.,; I. B. Sipahioglu, M.D.; Hormones for Improved Sexuality in the Male and Female Climacteric. **Drug Therapy,** Sept. 1976.

DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE: Robert B. Greenblatt, M.D.,** and **D. H. Perez, M.D.:** "The Menopausal Syndrome," *Problems of Libido in the Elderly*, pp. 95-101. Medcom Press, N.Y., 1974. **HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

BROWN **THE BROWN PHARMACEUTICAL CO., INC.** 2500 West Sixth Street, Los Angeles, California 90057

REFER TO PDR

Write for Reprints and Samples.

Know your taxes

Investments rundown—overview of the field

Donald L. DeMuth, M.B.A., C.P.A.
Edward H. Achorn, M.Adm., C.P.A.

Physicians are often confronted with and confounded by articles on a single phase of investment. For example, *Medical Economics* in its annual subject index for 1977 offers the following articles under the heading of Investments: "Your Best Investment Moves This Year," "Tailoring Your Investment Strategy to the New Tax Rules," "Tax Shelters That Still Make Sense," "The Best Short-term Run For Your Money," "Found: Another Super Way to Lose Your Shirt," and "What's No Longer as Good as Gold?"

The physician rarely finds an article which is confined to explaining the various features of different types of investments. This article proposes to explore the main features of a variety of investments. While it is not devoted exclusively to taxes, as the others in this series, it will be useful to the doctor in his financial planning.

Common stocks

Shares of common stock represent the residual equity interest of a company, i.e., common stockholders are entitled to what's left over after bondholders and preferred stockholders take their cuts. Common stockholders anticipate that shares they purchase will appreciate in price and perhaps also will pay dividends.

Common shareholders elect the members of the board of directors and control management. As a practical matter, if a physician-investor is dissatisfied with the management of a company in which he has invested, he will probably sell the stock and buy the securities of a company whose management wins his approval.

Securities may either be listed on a stock exchange or traded over-the-counter (O-T-C). The largest and most widely known stock exchanges in the United States are the New York Stock Exchange and the American Stock Exchange. All companies are originally traded O-T-C. Upon reaching a certain asset size, income amount, and specified distribution of common stock, a company may apply to be listed on one of the stock exchanges. Not all securities traded in the O-T-C market are small companies.

Stock market averages indicate how most securities are fairing. The most popular average is the Dow Jones Industrial Average, comprised of 30 large industrial corporations including General Motors, DuPont, and Exxon. A rise in the Dow Jones Industrial Average often indicates that other stocks have risen, too. The converse is also true.

Stocks are traded in round lots and odd lots. A round lot is 100 shares of stock; an odd lot is fewer than 100 shares of stock. In Wall Street parlance, if a doctor orders 375 shares of stock, he is ordering three round lots and an odd lot of 75 shares.

An investor may acquire stock through a stockbroker by buying on a cash account or on margin. If an M.D.-investor were to buy 100 shares of a stock trading at $50 through a cash account, he would pay a broker $5,000 (100 shares times $50 per share, ignoring commissions). When buying on margin the doctor pays the broker $2,500 and borrows the other $2,500 from him.

The advantage of buying on margin is that an investor can obtain twice the return per dollar invested if the price of the stock rises. If the stock rises by a dollar per share, for example, the investor who owns 100 shares will have increased the value of his stock by $100. One hundred dollars is a 2 percent increase to the investor who has $5,000 invested with the cash account. The investor with the margin account will have had his investment of $2,500 increased by 4 percent.

Conversely, if the stock drops by a dollar per share, the investor with the cash account has lost only 2 percent, while the investor with the margin account has lost 4 percent of his investment.

The authors recommend *A Random Walk Down Wall Street* by Burton Malkiel for further information about common stocks and investing.

The authors are on the faculty of the Pennsylvania State University's Capitol Campus, Middletown. Mr. DeMuth is an assistant professor of accounting and finance and Mr. Achorn is an assistant professor of accounting and management. For reprints write Mr. DeMuth or Mr. Achorn at the Pennsylvania State University, Middletown, PA 17057.

Bonds

A doctor-investor may want to acquire bonds because bonds pay a stated interest amount and at a specified time in the future pay a $1,000 maturity value. Interest on bonds remains constant and does not fluctuate as dividends do. If a company does not pay the interest on its bonds, it is in default of its bond indenture, while there is nothing that legally prevents it from not paying a dividend. The investor will also receive the face or maturity value of the bond, which is typically $1,000 for corporate bonds, when it matures at a specified future date. The company is not required to repurchase its common stock at a specified price by any future time.

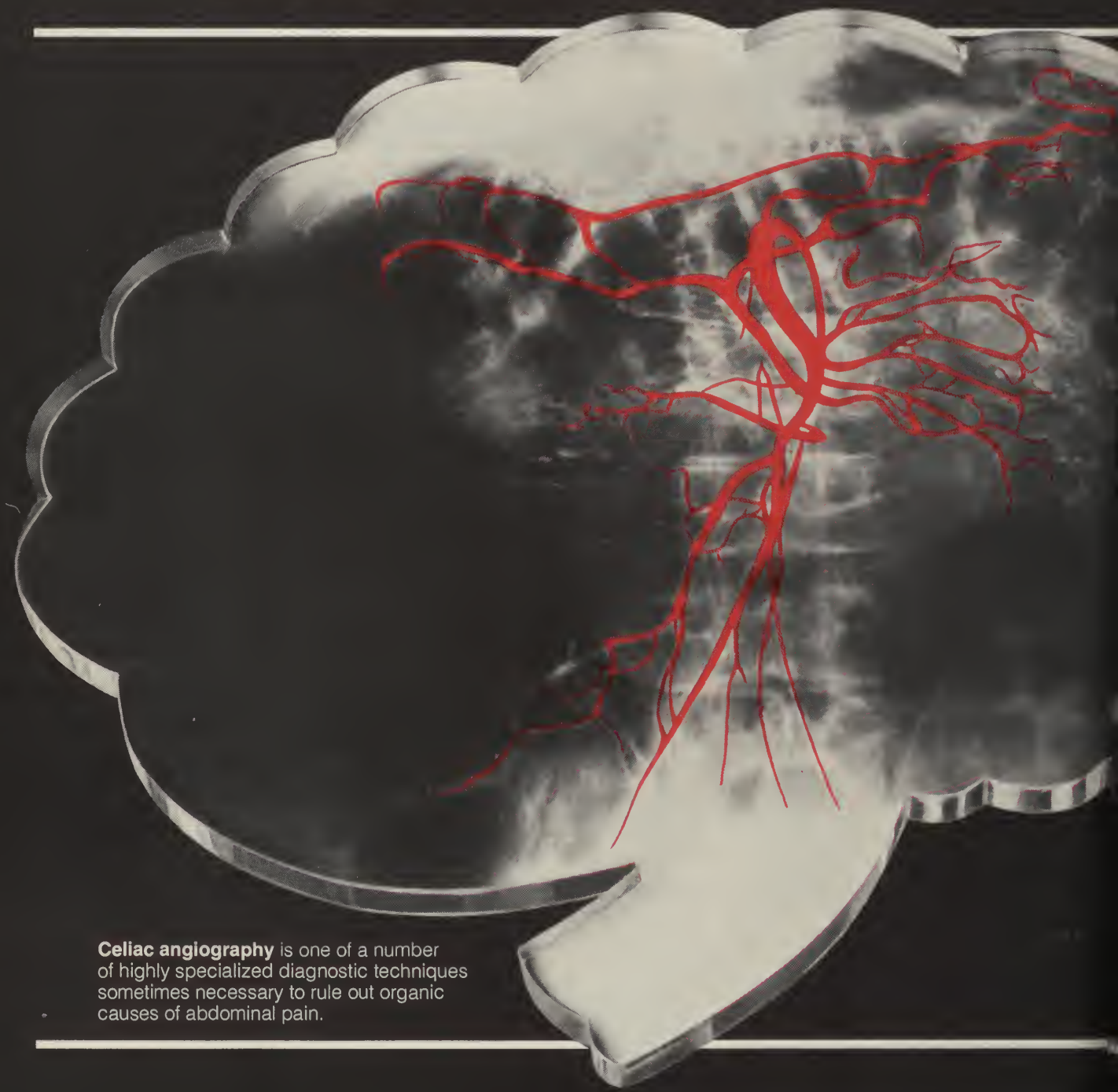
The rights accompanying a bond include preference in liquidation, which means if the company goes bankrupt the bondholders and other creditors must receive all money returned before stockholders receive anything. Bondholders are creditors and, as such, do not have the control over management affairs that stockholders have. Bonds are generally less risky than common stock.

Municipal bonds

Municipal bonds are issued by cities or states. They differ from corporate bonds in that the interest on municipal bonds is not taxed by the federal government. An investor who earns 6 percent interest on a municipal bond keeps the entire amount and does not

Continued on page 46.

THE LOWER G.I. TRACT: ORGANICALLY SOUND



Celiac angiography is one of a number of highly specialized diagnostic techniques sometimes necessary to rule out organic causes of abdominal pain.

...BUT OVERSENSITIVE TO EMOTIONAL STRESS



IN IRRITABLE BOWEL SYNDROME* LIBRAX PROVIDES DISTINCTIVE ADVANTAGES

- the specific antianxiety action of Librium®(chlordiazepoxide HCl)
- the potent antispasmodic action of Quarzan®(clidinium Br)

Adjunctive/Dual-Action

LIBRAX®

Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

A clear treatment advantage for patients with irritable bowel syndrome

ROCHE

*This drug has been evaluated as possibly effective for this indication.
Please see following page for brief summary of prescribing information.

A CLEAR TREATMENT ADVANTAGE FOR PATIENTS WITH IRRITABLE BOWEL SYNDROME*



Adjunctive/Dual-Action LIBRAX®

Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

ONLY LIBRAX PROVIDES THE SPECIFIC ANTIANXIETY ACTION OF LIBRIUM® (chlordiazepoxide HCl) PLUS THE POTENT ANTISPASMODIC ACTION OF QUARZAN® (clidinium Br)

Please consult complete prescribing information, a summary of which follows:

* **Indications:** Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:
"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.
Final classification of the less-than-effective indications requires further investigation.

Contraindications: Patients with glaucoma; prostatic hypertrophy and benign bladder neck obstruction; known hypersensitivity to chlordiazepoxide hydrochloride and/or clidinium bromide.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering Librium® (chlordiazepoxide hydrochloride) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

As with all anticholinergic drugs, an inhibiting effect on lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude development of ataxia, oversedation or confusion (not more than two capsules per day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacologic effects of agents, particularly potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: No side effects or manifestations not seen with either compound alone have been reported with Librax. When chlordiazepoxide hydrochloride is used alone, drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are avoidable in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally with chlordiazepoxide hydrochloride, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax are typical of anticholinergic agents, *i.e.*, dryness of the mouth, blurring of vision, urinary hesitancy and constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

Dosage: Individualize for maximum beneficial effects. Usual maintenance dose is 1 or 2 capsules, 3 or 4 times a day, before meals and at bedtime. Geriatric patients—see Precautions.

How Supplied: Librax is available in green capsules, each containing 5 mg chlordiazepoxide hydrochloride (Librium®) and 2.5 mg clidinium bromide (Quarzan®)—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 50, available singly and in trays of 10.

ROCHE

Roche Products Inc.
Manati, Puerto Rico 00701

Protecting your practice from embezzlement

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Seldom does a physician seriously suspect that one or more of his employes is dishonest. In spite of this, embezzlements do occur in medical offices.

Because doctors generally are preoccupied with patient care matters and thus often tend to ignore good accounting control principles, physicians' offices are prime targets for nearly undiscoverable theft by employes.

This article will explore some of the areas of exposure, the symptoms, and some thoughts regarding prevention of theft and embezzlement in medical offices.

Application of these principles can help diminish the likelihood of such losses, although there is no foolproof approach.

Exposures

Theft and embezzlement in a medical practice may take several forms.

• The most apparent modus operandi is the pilfering of patients' cash payments. In a "loose" system, it takes little imagination to envision how a receptionist or other employe handling cash could embezzle the funds.

A sound cash control system is required in a practice. The section on prevention will set forth some examples.

• Checks are another potential source of embezzlement difficulties.

An employe may ask the physician to sign a blank check "to save time." Once a blank check has been signed properly the employe can fill in her name or that of a friend and have the check cashed.

Checks made out to "Cash" are easily negotiable and should be avoided if possible. Such checks make it difficult to trace the payee.

The forged endorsement of a check by an unauthorized employe may present difficulties and calls for close review of checks.

An insurance overpayment, usually made because a patient has paid more than his share of a bill, provides the employe with an opportunity to "take" the difference over and above the amount owed. There is no suspicion on the part of the patient because he no longer receives bills. The doctor's office may remain unaware since the amount is fully paid and a zero balance appears on the bill.

• Petty cash funds may lead to theft problems that are not so "petty." An office may have more than $50 available in petty cash, and a programed and regular embezzling from this account by a determined employe can cause problems. It is important that a review and audit of petty cash is carried out periodically by someone other than the individuals who handle it on a regular basis.

• Money is not the only thing that can be stolen from a medical practice. Drugs, supplies, and other office materials can be taken easily from an office, particularly when the doctor is not often in the office at closing time.

It is a good idea to make someone responsible for ordering drugs and supplies and to have an independent party (a doctor or office manager, depending on circumstances) review the records periodically to let the staff know that someone is looking at things critically and to uncover any problems that might arise.

• A "third party conspiracy" in which an employe conspires with someone outside the practice may take several forms.

Salesmen "in cahoots" with an employe may charge more than is reasonable for a specific item or bill for items never received and then split the profits with the employe. An overseer of the supply ordering process may again be valuable in picking up discrepancies.

• A small medical practice is not likely to face the problem of an overstated payroll, but "phantom" employes may be paid by larger employers, such as municipalities and hospitals. It is also possible that the bookkeeper for a smaller practice could add a few dollars to selected paychecks. Personnel records should be checked periodically to assure authorized wages are paid.

The authors are the principal consultants of Management Consulting for Professionals, Inc., Bala Cynwyd.

Symptoms

The physician, office manager, or advisor may be alerted to theft problems in several ways.

• A declining collection ratio (receipts divided by charges) may be cause for concern if there is no other logical explanation for the decline. If work has been steady or growing at a conservative rate, a sharp drop-off in collection experience could indicate a problem.

• When an unexplained or unusual cash flow exists in a practice, the handling of cash should be reviewed critically.

• Unexplained accounts receivable trends may also be a tip-off.

If accounts receivable are dramatically increasing while productivity is relatively flat, for example, one must begin to wonder why collections have not kept up the pace. Embezzlement may have caused accounts receivable to increase with production without a corresponding increase in collections.

• Dramatic increases in drug and supply costs without reasonable explanation may also serve as an alarm that theft is taking place.

• Many physicians are surprised by the next "symptom."

No one should suspect an employe of

dishonesty without reason, but an overly conscientious assistant may be the prime candidate for an embezzlement.

If a bookkeeper maintains unduly long working hours, never taking time off for illness or vacation, and keeping all financial responsibilities to herself, she may be covering up an embezzlement. In simple language, she may be trying to keep everyone away from the books.

In the assistant's mind, the long hard hours of work over the years might have given her justification for taking the money, especially since she has "helped the doctor make so much money."

• Employes showing unusual emotional stress or experiencing personal financial difficulties are potential candidates for embezzlement. If an assistant's husband has lost his job, there may be strong pressures on her for additional funds. A doctor's office generating higher income due in part to that employe's help (even though she has not rendered medical care) may cause her to feel justified in an embezzlement.

Although it may seem extreme, another symptom could be a dramatic increase in an employe's standard of living. There have been circumstances in which a $10,000 a year assistant suddenly began driving a $10,000 automobile.

• Constant discrepancies in accounting—in balancing the checkbook or tallying the "day sheet" so that deposits equal cash and checks—can signal a problem. If accounting discrepancies never occur, it may be because a very sly individual is handling the books. Both extremes may be detected with the system of careful "audits" described below.

• A final symptom is a progressively disrespectful attitude on the part of an employe. She may begin to feel so confident that she has hidden her tracks and taken advantage of the practice that it may begin to show in her attitude toward work and her employer.

Preventive measures

There is no foolproof system that guarantees an employer that his practice is free from embezzlement, but conscientious application of several basic principles can make it more difficult for someone to steal.

• Hire well. Follow up references and develop a thorough interviewing process. Theft often can be diminished when the physician does a good job of hiring.

• Once good and qualified employes have been found, it is important to cultivate their loyalty to the practice. Practices that are similar in volume of work, specialty, number of doctors, and even location may be vastly different in terms of staff loyalty. "Teamwork" can diminish the risk of theft.

• All employes involved in handling incoming or outgoing funds should be bonded. A key question we ask on employment applications is whether the prospective employe would refuse to be bonded. Such a refusal probably indicates a bad experience that is on record with the bonding companies.

A reference check of previous employers often provides information about whether the employe has been bonded in the past, whether she had handled cash or other valuables, and whether the previous employer feels she did a good job.

• A regular control of accounts receivable is important to theft prevention. Far too many practices are unaware of the status of accounts receivable at a given time.

We recommend that every medical office compute accounts receivable regularly, whether the process is built into a formal system (e.g., pegboard) or is developed individually.

Once a sound beginning figure is established for accounts receivable, at the end of every month the charges for that month can be added to the figure, receipts and write-offs can be subtracted, and a realistic accounts receivable figure obtained. This is a helpful first step.

As a checking mechanism, at least twice a year (and preferably monthly) a tape should be run of all outstanding accounts. Although the tape often will not equal the regularly kept accounts receivable figure due to mathematical or other errors, it should come close to the correct figure. If not, an embezzlement problem may exist. This is particularly true if the tallying of the accounts receivable cards shows a much smaller figure than does the running total.

Besides being an excellent embezzlement control review, it also helps prevent loss of charges and cards. Practices that have used this system have sometimes found that cards were lost in drawers, put in the zero balance files, or even in someone's office or home. If the "accounts receivable balancing" had not been run, the funds would have been lost forever.

• The increased emphasis on "collection at the source" in medical practices increases the amount of cash available for theft. Thus the practice should assure that a system for recording office charges and collections is as foolproof as possible.

An outstanding feature of a pegboard billing system is embezzlement control. Each office visit patient is handed a slip showing the charges incurred and the payments received that day. The receptionist's record of this information is duplicated simultaneously on a day sheet and the patient's ledger card with the write-it-once approach. The likelihood of handing a patient a slip not listing a payment just received is minimal. Alteration of the carbon entries on the day sheet or ledger card is also apparent.

Computer and posting machine billing systems also can be safeguarded. A common approach is to have a two or three part fee slip with carbons on which entries are made. The top copy is handed to the patient as a receipt, thus involving the patient in the control system.

The day sheets should be totaled each day and reconciled with the cash and checks received during the day. In many cases the receptionist is expected to handle this closing out process each day, therefore making her accountable for her work. The bookkeeper or office manager receiving the materials should review critically the books and deposit the receipts.

• Another preventive measure requires outside, periodic surveillance of the books and records. This should be performed by the practice's accountant or medical management consultant.

A full scale audit of the books is not necessary; however, letting the staff know that an "outside expert" reviews the books periodically on an unannounced basis should prove to be a good preventive measure.

Many accountants for medical practices have been deficient in this area. Some feel that if they attempt an audit and an embezzlement is discovered, they will be more liable than if they had not checked. We disagree with this logic. No accountant can be expected to develop and guarantee an embezzlement-proof system, although he should make an effort to lessen the probability of theft.

• Often the most effective audit control is the doctor's own attention. This may involve only an occasional few minutes of physician time in informal and irregular audits.

A doctor should check isolated portions of his assistants' work on no particular schedule. This might be coordinated through the accountant or medical management consultant so that some guidelines can be established.

For example, the doctor might check each name on an appointment book for a specific date to the same names on that day's summary sheet and to entries to those patients' ledger cards.

This testing should not follow a pattern for time or matters reviewed. It serves more as a deterrent than as a discovery device, for an assistant who knows that her efforts to steal might be caught by this random process will be hard put to create a pattern on which she can rely. For this reason, this "audit" should be performed openly. The physician should explain that the procedure is being done for the doctor's and the assistant's protection at the accountant's or consultant's recommendation.

• Except when a practice is of clinic size, a physician should sign every check. This helps to discourage a bookkeeper from writing unauthorized checks. In addition, it has the advantage of keeping the doctor informed of where money is being expended.

The bookkeeper should be required to fill out each check completely, attaching the bill or invoice and putting them in a special file for the doctor's signature. It is important that incomplete checks (such as blank checks) are never signed and that one is critical of checks made out to cash or to suppliers or individuals without an invoice or with incomplete or confusing invoices. Here again, the fact that the bookkeeper knows that the doctor signs the checks and reviews the invoices can help serve as a deterrent.

The special file might be an unusually colored plastic folder so that the doctor will recognize it readily. He can sign a batch of checks in a few spare minutes while looking at each invoice to see where the money is going. This process makes the doctor aware of expenditures and should cause him to ask questions about anything that may not seem proper.

In group practices, the signature of any one of the doctors should be sufficient for routine expenditures. A policy which makes each doctor responsible for signing checks for alternating periods of time (perhaps three months) is desirable. It helps prevent the bookkeeper from avoiding inquiry by spreading similar checks among signers, and gives each doctor a better feel for expense levels of the practice as a whole.

• Lastly, the physician/employer should avoid the possibility of being exposed to extortion.

The two most common situations in which this can arise deal with tax problems (such as tax evasion) and personal relations (such as extramarital involvement with an employe).

These two points may seem too obvious to mention, but they have haunted physicians in the past and should be avoided. When such cases have arisen, the doctor has been powerless to act against a known embezzler in light of the circumstances.

We recognize that the potential for theft or embezzlement in a medical practice is present in a surprisingly large number of practices. No one can establish a system that is 100 percent embezzlement-proof. The problem can be avoided, however, with recognition of the exposures and symptoms and application of effective preventive measures. □

Preliminary Call to the 1978 Annual Session House of Delegates

The 1978 Annual Session of the House of Delegates of the Pennsylvania Medical Society will be called to order at the Host Farm Resort Motel, Lancaster, Pennsylvania, on Monday, October 30, 1978. The second session of the House of Delegates is scheduled for Tuesday, October 31, 1978. The third and concluding session of the House of Delegates will be held Wednesday, November 1, 1978. Since the third session may last into mid-afternoon, delegates should plan accordingly.

All proposed amendments to the Constitution must be submitted to the Office of the Secretary of this Society on or before June 30, 1978. Such amendments may be proposed upon the written petition of 15 Active, Senior/Active, or Intern/Resident members of the Society, or by the Committee on Constitution and Bylaws. While there is no specific requirement that Bylaw amendments be submitted in advance or published in the Official Call, this is preferable when possible. Written resolutions to be considered by the House may be submitted to the Secretary by a delegate acting in his own behalf or for the component county medical society or specialty society he represents. If received prior to September 30, 1978, they will be published in the *Official Reports Book*.

G. Winfield Yarnall, M.D.
Secretary

Investments rundown—overview of the field

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pay federal income tax on the interest. Note that although the interest on municipal bonds is not taxed for federal purposes, if an investor buys the bond and sells it for a gain, he must pay capital gains tax.

An attraction of municipal bonds is that a Pennsylvania resident buying securities of a Pennsylvania municipality does not have to pay state income tax on the interest. If he owns the bonds of out-of-state municipalities, he will have to pay the 2 percent state income tax on that interest.

A general rule of thumb to determine the amount of interest a physician would have to earn from a corporate bond on which interest is taxed, versus a municipal bond is: Take the percentage interest rate received and divide by one minus the M.D.'s tax bracket. For example, a doctor-investor in the 40 percent tax bracket earns 6 percent interest from a municipal bond. Table 1 shows the rate of interest he must earn before taxes to end up with 6 percent after income tax. Note that he would have to earn 10 percent before taxes to end up with a 6 percent after-tax return.

Table 1. Tax-Free Interest. Effective Before-Tax Yield.

Before tax equivalent

$$= \frac{\text{Percentage received}}{\text{1-tax bracket}}$$

$$= \frac{6\%}{1\text{-}40\%} = \frac{.06}{.6} = 10\%$$

Mutual funds

The municipal bond mutual fund is a new investment vehicle available to investors. A municipal bond mutual fund operates like the mutual funds for common stocks and corporate bonds, but invests only in tax-free municipal bonds.

A mutal fund results when many investors pool their money. The management of the fund acquires a securities portfolio of which each investor receives a slice. If the mutual fund managers invest the money equally in 100 different companies, an investor who places $1,000 in the mutual fund essentially has invested $10 in each of the companies. The mutual fund manager administers the investment in the 100 companies and sends the investor a statement of the results for the total investment.

Many investors have the notion that a mutual fund does two things: it gives them a diversified portfolio of securities with only a small investment; and, given its professional management, it should be able to earn a higher return than an individual could earn through his own efforts. While it is true that a mutual fund provides a diversified portfolio of securities for a small investment, it has been proven empirically that mutual funds do not earn any greater return, on average, than a randomly selected portfolio.

While a mutual fund does not give a doctor a better return than he might have netted on his own, it does provide him with a diversified portfolio and allows him to choose his level of risk.

Mutual funds fall into two categories—the load and no-load. A load fund charges a commission, typically 8½ percent of the amount of the investment, when the shares are purchased. A no-load fund charges no commission.

One doctor invests $1,000 in a typical load fund and another invests $1,000 in a no-load fund. The investor in the load fund pays $85 in commissions (8½ percent of $1,000) when he buys his shares. This leaves him with $915 actually invested. His counterpart who invests in the no-load fund has invested the entire $1,000. If both funds earn a 10 percent return on the amount of money actually invested, the physician who chose the load fund will have earned $91.50 (10 percent x $915) to end up with a total of $1,006.50 at the end of the year; the doctor-investor in the no-load fund will have earned $100 (10 percent x $1,000), and will have $1,100 at the end of the year.

If both funds continue to earn the same percentage return, the no-load fund invariably will earn more than the load fund. Again, it has been shown empirically that no earnings difference exists between load funds and no-load funds. Thus it is recommended that physicians confine themselves to no-load funds when making mutual funds investments.

Preferred stock

The features of preferred stock are actually a hybrid of those of common stock and bonds. A preferred stock pays a dividend just as common stock may, but the dividend remains constant. The price change of a preferred stock is geared more to a change in interest rates than to a change in the fortune of the particular company which issued them. A preferred stock does not have to be redeemed by the issuing corporation. Preferred stockholders and bondholders have no vote in the corporation's management. In the event of bankruptcy liquidation, bondholders and creditors recover their entire debt before preferred stockholders receive any payment. Thus preferred stock has all the disadvantages of common stocks and bonds and none of the advantages.

Savings accounts and certificates of deposit

Do not overlook the investment of cash in your financial planning. Prudent physicians should have from three to six months of income, after income taxes and social security taxes, in some form of cash. This offers protection in case of emergency and provides liquidity to take advantage of investment opportunities. The return earned on savings accounts or certificates of deposit in a savings and loan association or savings bank is through accounts from which the depositor can withdraw the money daily at 5¼ percent; through a one-year certificate of deposit, 6½ percent; 2½-year certificate of deposit, 6¾ percent; and 4-year certificate of deposit, 7½ percent. This is higher than the maximum return legally earned from a commercial bank, which is 5 percent on a passbook account, 6 percent on a one-year certificate of deposit, 6½ percent for 2½ years, and 7¼ percent for four years.

When a depositor invests in a certificate of deposit (C.D.) which extends for a year or longer, he must re-

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Relationship studied in Pennsylvania

Guillain-Barré syndrome and influenza immunization

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H. James Beecham, III, M.D.
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Robert G. Sharrar, M.D.
John C. Harris, M.D.

On October 8, 1976, the Pennsylvania Department of Health launched its Influenza Immunization Program, joining the Allegheny County Health Department and the Philadelphia Department of Public Health in a national program to protect the citizens of the Commonwealth against a possible epidemic of influenza A/New Jersey/76 ($H_{sw1}N_1$, "swine flu"). During the next two and a half months, nearly 2.9 million residents of the Commonwealth received monovalent (A/New Jersey/76) or bivalent (A/New Jersey/76 and A/Victoria/75) influenza vaccine.

On December 16, 1976 the U.S. Department of Health, Education, and Welfare announced a moratorium on influenza inoculations based on:

1. A suggested increased risk of Guillain-Barré syndrome among vaccinated persons
2. A concentration of Guillain-Barré cases with onset 2-3 weeks after vaccination
3. Absence of an adequate Guillain-Barré data base to assist in interpreting the above findings

All influenza immunization programs in Pennsylvania were immediately terminated, and an intensive effort was begun to identify all cases of Guillain-Barré syndrome and to analyze the association of cases with influenza immunization.

Methods

A case definition was supplied by Richard Tenser, M.D., and his associates in the department of neurology at the Pennsylvania State University College of Medicine in Hershey. An individual was accepted as a case of Guillain-Barré syndrome if he met the following criteria:

1. Onset develops subacutely with the full syndrome developing 1 to 7 days after the initial symptoms
2. Marked weakness of one or both sets of extremities, always symmetrical but not always precisely equal
3. Areflexia to marked hyporeflexia in the areas of weakness

Immediately after the moratorium was announced, health department personnel contacted all hospitals in the state in an effort to identify Guillain-Barré cases. Active surveillance with the hospitals was continued through January 1977, and one final effort to identify late cases was initiated in late March.

Mailgrams were sent on December 22 to members of the American Boards of Psychiatry and Neurology in Pennsylvania in an effort to identify additional cases. The Bureau of Health Communications prepared articles for the news media indicating an interest in being informed of all cases of Guillain-Barré syndrome. Cases with onset between September 15, 1976 and January 31, 1977 were sought.

A short epidemiologic form was completed for each possible case reported to the health departments. The form included such information as patient's name, address, age, sex, race; influenza vaccination history; date of onset of Guillain-Barré; hospital name and address; physician's name, address, and telephone number; and information regarding lumbar puncture, mechanical respiratory assistance, and death.

Contact was made with the attending physician of each suspect case by one of the three epidemiology units in the Commonwealth, i.e., Division of Communicable Disease Control of the Pennsylvania Department of Health, Supportive Services of the Allegheny County Health Department, and Communicable Disease Control Section of the Philadelphia Department of Public Health. A more complete epidemiologic form was sent to attending physicians of each patient meeting the case definition.

Completed forms were returned to one of the three epidemiology units, where they were compiled for analysis. A copy of each completed form was

Drs. Parkin and Beecham are associated with the Division of Communicable Disease Control of the Pennsylvania Department of Health. Dr. Beecham also serves with the Field Services Division, Bureau of Epidemiology, of the National Center for Disease Control. Ms. Streiff is on the staff of Supportive Services for the Allegheny County Health Department. Dr. Sharrar was on the staff of the Communicable Disease Control Section of the Philadelphia Department of Public Health at the time of the study and is now at the University of Pennsylvania School of Medicine. Dr. Harris, now at the University of Colorado Medical Center in Denver, was with the Field Services Division of the CDC and the Philadelphia Department of Public Health when this study was conducted.

sent to the Center for Disease Control in Atlanta for inclusion in national data.

Results

A total of 56 cases of Guillain-Barré syndrome met the case definition. Detailed epidemiologic forms were received for 53 of these cases. The 56 patients ranged in age from 1 to 81 years, with a mean age of 44.9 years at the time of onset. The male:female ratio was nearly equal at 29:27. The dates of onset ranged from September 15, 1976 to January 31, 1977. An unusual clustering of cases occurred between the weeks of November 28 and December 19, 1976 (Fig. 1). Cases were reported in 24 of Pennsylvania's 67 counties and at least 85 percent of patients were seen by neurologists or neurosurgeons. Two of the 56 patients had Guillain-Barré syndrome previously. All but one of the 52 patients reporting race were white.

Thirty-six (64 percent) of the 56 Guillain-Barré patients gave a history of receiving influenza vaccine prior to the onset of the illness. The remaining 20 (36 percent) denied having received influenza vaccine. The period from influenza inoculation to onset of Guillain-Barré syndrome ranged from less than one day to 102 days. More than 80 percent of the cases in vaccinated patients occurred within five weeks of influenza inoculation (Fig. 2).

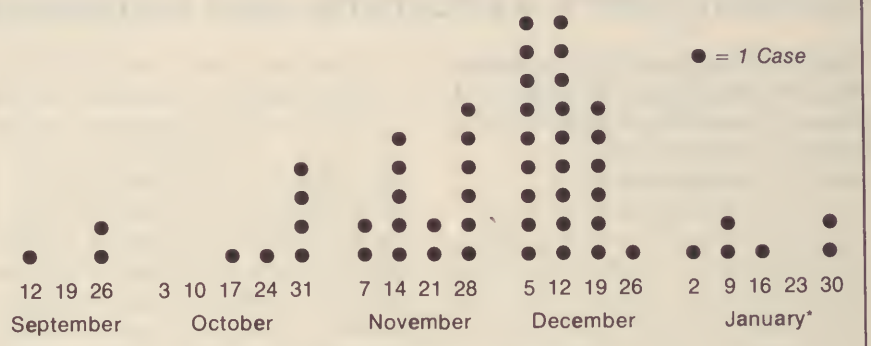
Because a clustering of cases was noted during the first five weeks following influenza inoculation, the data were analyzed using two groups of vaccinated patients: Group A were those with "incubation periods" of less than five weeks, and Group B were those with onset at 36 or more days after inoculation. Figure 3 depicts the epidemic curves for each of the two vaccinated groups and for the non-vaccinated group (Group NV). Information about four vaccinated cases was insufficient and thus they were not included in either group.

The mean age of patients receiving influenza vaccine was 51.3 years, and a greater proportion ($.01 > p > .001$) in this group than in the non-vaccinated group were over 40 years.

Table 1 presents certain characteristics of the three groups of

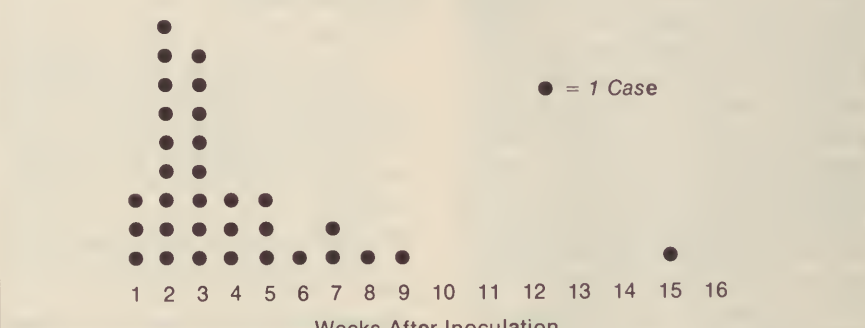
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FIGURE 1. All Guillain-Barré Syndrome Cases in Pennsylvania By Week of Onset



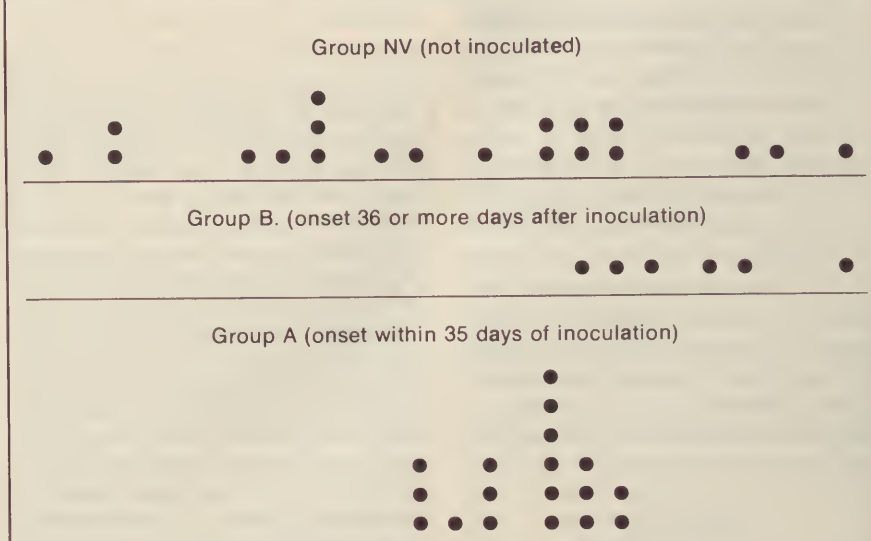
* One case reported only as "January onset"

FIGURE 2. Onset of Guillain-Barré Syndrome by Week After Inoculation with Influenza Vaccine*



* Date of inoculation not documented for 4 cases

FIGURE 3. Onset of Guillain-Barré Syndrome Cases in Pennsylvania By Week of Onset*



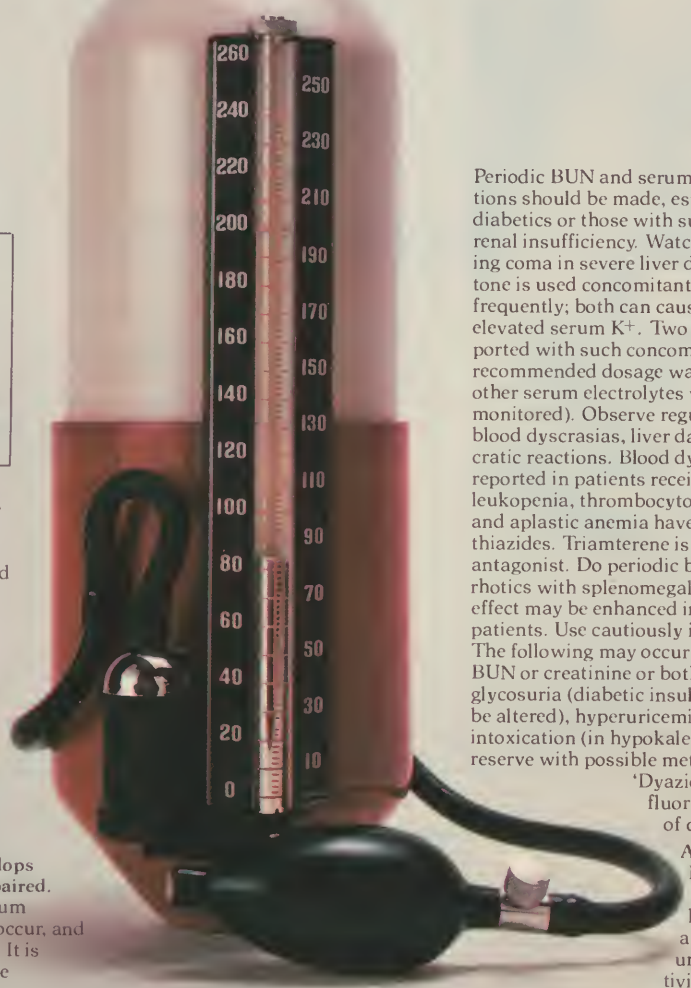
* Date of inoculation not documented for 4 cases

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Each capsule contains 50 mg. of Dyrenium® (triamterene, SK&F Co.) and 25 mg. of hydrochlorothiazide.

MAKES SENSE



Before prescribing, see complete prescribing information in SK&F Co. literature or PDR. A brief summary follows:

* Warning
This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

* **Indications:** When the combination represents the dosage determined by titration: Adjunctive therapy in edema associated with congestive heart failure, hepatic cirrhosis, the nephrotic syndrome. Corticosteroid and estrogen-induced edema, idiopathic edema; hypertension, when the potassium sparing action of triamterene is warranted. (See Box Warning.) Routine use of diuretics in healthy pregnant women is inappropriate; they are indicated in pregnancy only when edema is due to pathological causes.

Contraindications: Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K^+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K^+ frequently; both can cause K^+ retention and elevated serum K^+. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis.

'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

Supplied: Bottles of 100 and 1000 capsules; Single Unit Packages of 100 (intended for institutional use only).

FOR LONG-TERM CONTROL OF HYPERTENSION.* SERUM K^+ AND BUN SHOULD BE CHECKED PERIODICALLY. (SEE WARNINGS SECTION.)

SK&F CO., Carolina, P.R. 00630

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TABLE 1. Characteristics of Three Groups of Guillain-Barré Syndrome Cases

Age (years)	*Group A*[1]	*Group B*[2]	*Group NV*[3]
Range	31-81	23-66	1-62
Mean	53.1	42	33.4
Mean-Male	52.8	49.5	34.4
Mean-Female	53.5	38.2	32.2
Sex			
Males	14	2	11
Females	12	4	9
Vaccine			
Monovalent	12	1	-
Bivalent	11	4	-
Unknown	3	1	-
"Incubation Period"[4]			
Range	<1-33	38-102	-
Mean	16.3	58.8	-

[1]Onset within 35 days of influenza inoculation
[2]Onset 36 or more days after influenza inoculation
[3]Not inoculated against influenza
[4]Period from influenza inoculation to onset of Guillain-Barré syndrome (days)

TABLE 2. Exposure to Possible or Predisposing Cause of Guillain-Barré Syndrome

Cause	*Group A*[1]	*Group B*[2]	*Group NV*[3]
Allergy	2/22 (9)[4]	0/5 (0)	1/17 (6)
Chronic illness	14/24 (58)	4/6 (67)	7/20 (35)
Medicine[5]	11/24 (46)	5/6 (83)	7/17 (41)
Acute illness[5]	8/23 (35)	2/5 (40)	6/17 (35)
Exposure to toxins	3/22 (14)	1/5 (20)	1/16 (6)
One or more causes	17/24 (71)	5/6 (83)	15/20 (75)
Mean causes	1.58	2.0	1.1
Two or more causes	13/24 (54)	5/6 (83)	6/20 (30)

[1]Onset within 35 days of influenza inoculation
[2]Onset 36 or more days after influenza inoculation
[3]Not inoculated against influenza
[4]No. with cause/no. responding (percent)
[5]Within four weeks prior to onset

TABLE 3. Age Distribution of Persons Receiving Influenza Vaccine[1]

Age Years	*Monovalent*	*Bivalent*	*All Vaccine*	*Not Vaccinated*[2]	*Total Pop.*
0-4	1,349	2,356	3,705	923,366	927,071
5-17	14,024	24,344	38,368	2,886,647	2,925,015
18-44	1,051,922	171,739	1,223,661	2,721,864	3,945,525
45-64	464,529	489,824	954,353	1,781,823	2,736,176
65+	2,815	595,031	597,846	669,133	1,266,979
Unknown	46,378	16,577	62,955	X	X
Total	1,581,017	1,299,871	2,880,888	8,919,878	11,800,766

[1]Vaccine administered during National Influenza Program by Pennsylvania, Allegheny County, and Philadelphia County programs as of April 1, 1977
[2]Based on 1970 census minus vaccinees

Continued from page 48.

Guillain-Barré syndrome patients. The number of patients 40 years of age or older is statistically significant in Group A when compared to Group NV ($.01 > p > .001$). There is no significant difference in age between Group B and Group NV. No statistically significant difference exists in the male:female ratio in the three groups, nor is there an appreciable difference in the type of vaccine received by the two vaccinated groups.

Patients were queried about personal histories for other possible or predisposing causes of Guillain-Barré syndrome, such as allergies, chronic illness, medicines or acute illnesses in the four weeks prior to onset, and exposure to toxins (Table 2). While no significant difference existed between vaccinated and non-vaccinated cases for these possible or predisposing causes, Group B varied significantly from group NV by having two or more possible predisposing causes of Guillain-Barré syndrome ($p=0.03$).

Monovalent or bivalent influenza vaccine was administered to 2,880,888 residents, or 24 percent of the Commonwealth population (Table 3). The attack rate of Guillain-Barré syndrome after vaccine was 1.25/100,000, while Guillain-Barré syndrome developed in only 0.22/100,000 of those not receiving the vaccine (Table 4).

Guillain-Barré syndrome did not occur in the nonimmunized group over the age of 65 or in the immunized group under 17 (only 42,000 were immunized in this age group). A case of Guillain-Barré syndrome occurred in about one of 80,000 vaccinees (1/122,000 monovalent, 1/76,000 bivalent) and in one of 446,000 individuals not vaccinated. Approximately one in 111,000 vaccinees developed the syndrome within five weeks of injection and one in 480,000 after five weeks. The relative risk of developing Guillain-Barré was 5.68 for all vaccinees and 4.09 for members of Group A.

The severity of the syndrome, based on motor involvement, was essentially the same in vaccinated and non-vaccinated cases. No significant difference in motor involvement was seen in Groups A, B, and NV (Table 5). When Group A cases were examined

TABLE 4. Attack Rates and Relative Risks of Guillain-Barré Syndrome in Pennsylvania

		Age (years)					
		0-4	5-17	18-44	45-64	65+	*Total*
Group NV	AR	0.11[1]	0.21	0.22	0.39	NC[2]	0.22
All	AR	NC	NC	0.89	1.57	1.67	1.25
Vaccinees	RR	-	-	4.05	4.02	-	5.68
Monovalent	AR	NC	NC	0.57	1.29	35.5	0.82
	RR	-	-	2.59	3.31	-	3.72
Bivalent	AR	NC	NC	1.75	1.43	1.18	1.31
	RR	-	-	7.95	3.67	-	5.95
Group A	AR	NC	NC	0.65	1.26	1.00	0.90
	RR	-	-	2.95	3.23	-	4.09
Monovalent	AR	NC	NC	0.47	1.29	35.5	0.76
	RR	-	-	2.14	3.31	-	3.45
Bivalent	AR	NC	NC	0.58	1.02	0.84	0.85
	RR	-	-	2.64	2.62	-	3.86
Group B	AR	NC	NC	0.24	0.21	0.16	0.21
	RR	-	-	1.09	0.54	-	0.95
Monovalent	AR	NC	NC	0.10	NC	NC	0.06
	RR	-	-	0.45	-	-	0.27
Bivalent	AR	NC	NC	1.16	0.20	0.17	0.31
	RR	-	-	5.27	0.51	-	1.41

[1]Per 100,000 population
[2]No cases

TABLE 5. Extent of Motor Involvement & Case-Fatality Ratio of Guillain-Barré Syndrome Cases

	Group A[1]	*Group B*[2]	*Group NV*[3]
3-4 limbs affected	22/24 (92)[4]	5/6 (83)	17/19 (89)
Trunk affected	10/20 (50)	3/4 (75)	9/16 (56)
Cranial nerves affected	10/23 (43)	1/4 (25)	9/17 (53)
Respiratory impairment	10/22 (45)	2/5 (40)	7/16 (44)
Placed on respirator	7/23 (30)	1/5 (20)	7/18 (39)
Case-fatality ratio	3/26 (12)	0/6 (0)	0/20 (0)

[1]Onset within 35 days of influenza inoculation
[2]Onset 36 or more days after influenza inoculation
[3]Not inoculated against influenza
[4]No. with involvement/no. responding (percent)

TABLE 6. Extent of Motor Involvement by Vaccine Received[1]

	Monovalent	*Bivalent*	*Statistical p value*[2]
Trunk affected	7/8	2/10	p=0.007
Cranial nerves affected	8/11	1/10	p=0.006
Respiratory impairment	6/9	2/11	p=0.04
Placed on respirator	4/10	2/11	p=0.21

[1]Group A cases only—onset within 35 days of influenza inoculation
[2]Fisher's Exact Test

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by type of vaccine received, however, individuals who had received monovalent vaccine had more trunk and cranial nerve involvement (Table 6).

Three Guillain-Barré syndrome patients died between 36 and 87 (mean=55.3) days after onset. The three were men 31, 46, and 65 years old who had received influenza vaccine 5, 12, and 31 days, respectively, before becoming ill. Two had received monovalent vaccine and one had received bivalent vaccine. All three had chronic underlying disease (one had had Guillain-Barré syndrome 15 years earlier), and two of the three had experienced an acute illness in the four weeks prior to onset of neurological symptoms.

Discussion

During the National Influenza Immunization Program, an unusual number of cases of Guillain-Barré syndrome were noted in individuals who had received influenza vaccine.[1] Because of the unexpected occurrence of this unusual syndrome, the National Influenza Immunization Program was suspended and an intensive investigation was launched to determine the relationship of Guillain-Barré syndrome to influenza immunization.

Individuals who received influenza vaccine were at more risk of developing Guillain-Barré syndrome than those who were not vaccinated. Data suggest a causal relationship between the inactivated influenza vaccines and the syndrome. Leneman,[2] in a review of the literature of 1,100 cases of Guillain-Barré, found one case associated with influenza vaccine. Thirty-one other cases were associated with vaccines, including rabies, tetanus, typhoid, pertussis, diphtheria, smallpox, and inactivated (Salk) poliomyelitis vaccines.

Nearly 75 percent of our patients gave histories of exposure to or experience with other factors that are thought to cause or contribute to Guillain-Barré syndrome. No difference was seen in vaccinated and non-vaccinated patients in frequency of occurrence of these factors, which included allergies, exposure to toxins, medicine or acute illness in the preceding four weeks, and chronic illness.

We found no difference in male/female ratio between vaccinated and non-vaccinated patients. As in the findings of McFarland *et al.*[3] and in contrast to those of Lesser *et al.*,[4] we found no preponderance of males.

Not surprisingly, the persons who received vaccine were older than those who did not, with a mean age difference of nearly 20 years. This corresponds with the ages of individuals who were offered vaccine, i.e., generally those 18 years of age and older.

Several items in the data suggest that Guillain-Barré syndrome may have occurred as a result of influenza immunization less than five weeks prior to the onset of symptoms. The epidemic curve showed a clustering of cases during the first five weeks after immunization. The attack rate for members of Group B (those individuals developing the syndrome 36 or more days after inoculation) resembled that of non-vaccinees in total and in individual age groups. Group B members were slightly younger than those in Group A (those developing the syndrome within five weeks of inoculation) but older than non-vaccinees (Group NV). Group A individuals were older than non-vaccinees and were at substantially greater risk of developing the syndrome. The three deaths occurred in individuals who had onset of the syndrome less than five weeks after receiving the influenza inoculation.

Guillain-Barré syndrome is not a reportable disease, so base-line data on the incidence of this condition do not exist. Detection of the unusual occurrence of Guillain-Barré syndrome was possible due to the intense surveillance system for vaccine reactions incorporated into the National Influenza Immunization Program. The association of Guillain-Barré syndrome with influenza immunization underlines the importance of surveillance to detect vaccine reactions and points out the difficulties inherent in attempting to assess the relationship between low frequency events and immunization procedures. □

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Investments rundown—overview of the field Continued from page 46.

member that, while he receives a higher interest rate, there is a penalty for early withdrawal. The penalty amounts to losing three months' interest and being paid interest equivalent only to the passbook savings rate for the remaining time of the account. Table 2 illustrates this point.

Table 2. Penalties for Early Withdrawal

	First year interest	
	4-year C.D. no penalty	4-year C.D. with penalty
Invested	$1,000	$1,000
Interest rate	x 7½%	x 5¼%
Interest earned	$ 75	$ 52.50
Penalty (3 months)	- 0	-13.13
Interest received	$ 75	$ 39.37

Real estate

Investors can expect to earn a higher return in real estate than in stocks, bonds, savings accounts, or other liquid investments of comparable risk for three major reasons.

First, in the securities market there is "perfect information." Investors in Los Angeles have as much information about a security, such as Xerox, as do Pennsylvania investors. Neither group is aware, most likely, of the real estate market in the other's area. Thus real estate investors can take advantage of privileged information which enables them to receive a higher return.

Second, the initial investment in real estate is much higher than is the initial investment to enter the stock market. For less than $100 an investor can buy shares of companies or shares of a mutual fund. An initial investment in real estate, however, is quite often many thousands of dollars.

The third reason is that a real estate investment is illiquid. While an investor can sell General Motors stock in five minutes, it may take weeks, months, or even years to sell a parcel of real estate.

Generally, raw land is a riskier investment than income-producing properties, such as apartment buildings or office buildings, because the investor must make mortgage payments and pay real estate taxes with no rental income inflow.

Let's examine the method by which income-producing real estate should be analyzed.

- After the potential real estate investor contacts a realtor, he should immediately review projections of rent and expenses for the property to determine whether the investment is financially viable. A primary rule to remember when reviewing these projections is: Do not trust the realtor's figures! He has probably obtained them from the property owner who often does not base the figures on sound documentation.

For example, gross rent invariably is stated as though the building were fully occupied for an entire year. No matter how choice the property, in the case of an apartment building, you inevitably will have some periods of vacancy. The physician should estimate an allowance for vacancy. In a nonurban area in central Pennsylvania, for example, a 5 to 10 percent vacancy allowance is probably reasonable.

- An investor can check real estate taxes by calling the Recorder of Deeds office at the county courthouse to locate the tax collector for the particular property which interests him. To determine the amount of real estate taxes most recently paid, the present owner's name and address and the "property number" are needed. From the Recorder of Deeds the prospective investor can discover what the present owner paid for his property and when it was bought.
- From the tax collector the investor can determine whether there are any delinquent taxes, which could indicate that the owner is in a tight financial position. Check when the last reassessment of the property was made and see if the tax collector knows when the next is likely to be.
- Get the present owner's permission to have the electric company disclose the previous year's electric bill, the number of kilowatt hours used, and the current price per kilowatt hour. Estimate the expected electrical use for the coming year. Because of the recent high cost of energy, desirable property has total electric heating with separate electric meters for each apartment so the tenants pay their own heat and electric bills.
- For water and sewage, get the owner's permission to call the municipal authority for last year's costs. Call the trash man for the number of hauls and the cost per haul for trash in the last year.
- If the building has oil heating, check with the oil dealer for the previous year's cost and the number of gallons used. Multiply the gallons used by the present cost per gallon to estimate next year's cost.
- Call your insurance agent and ask for the approximate cost of fire and liability insurance.
- Repairs and maintenance often are omitted in a realtor's analysis. Attempt to verify what it has been in the past. Try to uncover the owner's involvement in the apartment building. If he did a lot of the work himself, he may not have imputed a cost for his time.
- How about management? This, too, is often omitted. After all, who is going to be called about plumbing at midnight? Should one of the tenants who has a background in construction service the building for a reduction in his rent? Perhaps, but should he also collect the rent? Many realtors perform the management service; often they charge 5 to 10 percent of the gross rents for assuring that the work is completed, pay the bills, collect the rent, and remit the remaining portion to the investor.
- Remember that depreciation of the building is a tax deductible expense that does not require a cash payment.

Another source of information is the present owner's tax returns for the past five years or as many as are available. Tax returns are particularly good sources because nowhere else will income be lower or expenses higher than on an individual's tax return. For this reason, if the seller balks at allowing you to see this information, it may be a sign that he is attempting to hide something from you.

This article delineates the investment opportunities available to the M.D.-investor. The "right" investment is a personal decision. Everyone must assess the risks and potential outcome of the opportunities available to him and make the determination for himself. □

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Behavior therapy in primary care practice

Continued from page 27.

tation. For example, the increased electromyographic activity of the frontalis muscle associated with tension headaches can be communicated back to the patient as a variably pitched tone or by deflection of a needle on a meter. The patient is instructed to lower tone or keep the needle within a certain range by whatever strategy he can devise. As he does this, he decreases the activity of the frontalis muscle, learning to relax a part of his body and potentially warding off subsequent headaches.

Modifying consequences

Contingency management—Every action has some consequence, no matter how trivial. These consequences are called "reinforcers" and can be positive or negative. Positive reinforcement increases the probability of a behavior recurring; a negative reinforcer reduces the probability of recurrence. Individuals receiving reinforcement and those providing it are often unaware of these contingencies. Families of patients with anorexia nervosa, for example, often unwittingly reinforce not eating by providing attention for refusal to eat. Contingency management, therefore, is the planned manipulation of reinforcers to alter behavior.

In marital or family discord, the principle of contingency management can be used to devise a "behavioral contract" between the partners or among family members. With the assistance of the physician, each person specifies the behaviors he would like to see as forthcoming from the other. A trade-off is negotiated and agreed upon, and the net result is that each person rewards the other for the desired behavior and is in turn reinforced. Thus the tendency to continue the desired behavior is increased progressively. Negative reinforcers, such as nagging, arguments, or criticism, are reduced or eliminated by the contract method.

Extinction—It is possible to change behavior by removing all reinforcers, positive and negative. Childhood tantrum behavior can be managed in this way. Rather than being cuddled or scolded, the child is isolated and the tantrum ignored. If attention has maintained this behavior, removal of the reinforcers eventually leads to the decrease and disappearance of tantrum activity.

Aversive conditioning—Some behavior patterns are difficult to change because the immediate consequences are positively reinforcing even though the long-term consequences are negative. For example, the immediate effects of alcohol are pleasing to an alcoholic even though the long-term effects are not.

Aversion therapy attempts to condition the patient to dislike an object or situation. It has been used for cigarette smoking, alcoholism, obesity, and sexual deviations. In this approach, stimuli that commonly are associated with the undesirable behavior are paired simultaneously with a painful or unpleasant stimulus, resulting in suppression of the desired behavior. The taste and smell of certain fattening foods, for example, could be paired with imagery that is repugnant and distasteful so that the obese patient feels conditioned nausea when tempted to eat non-dietic food.

Applying behavior therapy

Behavioral interventions can be effective in treating a wide range of conditions (Table 1) commonly seen in a general medical practice, including: tension states, insomnia, phobias, obsessive-compulsive disorders, obesity, alcoholism and drug abuse, smoking, psychophysiologic disorders, sexual dysfunctions, marital discord, and childhood behavior disturbances.

Behavior therapy is practiced by a variety of treatment providers; psychiatrists and psychologists use behavioral approaches, and some psychiatric social workers and psychiatric nurse practitioners also receive training in the field. Most medical school psychiatry departments have staff members who are behavior therapists; if not, they usually can refer patients to trained affiliated faculty. However, not all problems that are responsive to behavior therapy require a high degree of expertise for treatment. Relaxation training, stimulus control analysis, and contingency management are techniques that can be learned and used by primary care physicians.

Behavior therapy techniques can be particularly useful in general medical practice because they are problem oriented, focus on very specific and limited change, and are compatible with other forms of counseling already familiar to physicians.

Because the primary care physician may be the first to recognize the problem, he is in a good position to make the initial intervention. By using the "ABC" principles of behavioral change, the physician can select circumstances to be manipulated. The patient and his spouse or parents can act as "auxiliary therapists," thereby increasing the patient's motivation and commitment to behavioral change.

When behavior change is indicated in the treatment of a patient, the physician must decide whether to provide treatment himself or refer the patient to a specialist in behavior therapy. It is important to emphasize that the undesirable side effects of behavior therapy are relatively benign. If the patient does not improve after a reasonable time, referral for formal therapy may be required.

Additional training in the application of behavioral procedures is available through continuing education courses, and some basic texts in the field provide further information.[1-4]

The techniques of behavior modification show considerable promise for improving the treatment of certain problems in medicine that primarily affect behavior. The practicing physician should be familiar with the basic principles of behavior therapy, for they can be an effective therapeutic adjunct in the management of a variety of disorders commonly seen in primary care practice. □

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TABLE 1. Applications of Behavior Therapy

Behavioral condition	*A(ntecedents)*	*B(ehavior)*	*C(onsequences)*
Tension states Medical procedures e.g., pelvic exams	Behavioral log Relaxation training Systematic desensitization		
Insomnia	Relaxation training Systematic desensitization	Regularize sleep habits Go to bed only when sleepy	
Phobias	Relaxation training Systematic desensitization Reinforced practice	Modeling	Contingency management
Obsessive-compulsive disorders	Relaxation training Systematic desensitization Reinforced practice	Negative practice Modeling	Contingency management
Obesity	Behavioral log Purchase only foods permitted on diet	Eat only in a designated place Slow down eating	Instruct in aversive consequences of overeating: Reinforce weight loss with praise Aversive imagery
Alcoholism and drug abuse	Note stimuli associated with craving Avoid associations and locations associated with use Relaxation Systematic desensitization	Shaping Modeling Assertiveness training	Instruct in aversive consequences of use Aversive imagery Contingency management
Smoking	Behavioral log Relaxation training Systematic desensitization	Gradual withdrawal of cigarettes or Decrease length of cigarettes	Instruct in aversive consequences of use
Psychophysiologic disorders	Relaxation training	Assertiveness training Biofeedback	
Sexual dysfunction	Relaxation training Systematic desensitization Reinforced practice	Shaping	Contingency management
Marital discord	Behavioral log	Shaping Modeling Role playing Assertiveness training	Contingency management Behavioral contract
Childhood behavior disorders			
Habit disturbances Tics Tantrums Stuttering	Behavioral log	Negative practice	Extinction Contingency management
School phobia	Systematic desensitization Reinforced practice	Shaping Modeling	Contingency management
Enuresis Toilet training Self care	Behavioral log	Conditioning Bladder apparatus and training Shaping	Contingency management
Discipline problems	Behavioral log	Shaping Modeling	Extinction Contingency management Behavioral contract

classifieds

PHYSICIANS WANTED

House Physicians—Positions available July 1, 1978. Must be licensed in Pennsylvania. Apply Northeastern Hospital, Tulip St. and Allegheny Ave., Philadelphia, PA 19124. For appointment with Medical Director telephone (215) 427-6420. Equal opportunity employer.

OB-GYN—Solo/group practice available with new 500-bed medical center in western Pennsylvania. Hospital will provide a minimum guaranteed income and complete office setup. Contact M. Benson, 3708 Fifth Ave., Pittsburgh, PA 15213; (412) 687-9700.

Child Psychiatrist—Private practice opportunity with 300-bed western Pennsylvania hospital located in very desirable residential community. Will be responsible for both medical and psychiatric evaluations. Minimum guaranteed income and complete office setup provided by the hospital. Contact M. Benson, 3708 Fifth Ave., Pittsburgh, PA 15213; (412) 687-9700.

ENT—Community hospital in beautiful Maryland setting near three metropolitan areas, guaranteed minimum income of $60,000 plus complete office setup for full spectrum of surgical practice. For complete details, contact Daniel Stern, 3708 Fifth Ave., Pittsburgh, PA 15213; (412) 687-9700.

State College Pennsylvania—Immediate opening for full-time ER physician in 24-hour department of 180-bed community hospital. 25,000 ED visits per year. Competitive salary and benefits. Excellent backup. Site of Penn State University with the best of rural and urban living. Minimal industry in area. Excellent public schools. Contact Tom Mebane, M.D., (814) 238-6852.

Emergency Room Director—We are a 210-bed community hospital located in southwestern Pennsylvania, twenty-five miles from Pittsburgh. We are seeking an A.C.E.P. board eligible physician to take complete charge of our recently constructed and fully equipped emergency department. Candidate must possess emergency medicine experience. In addition to our professional requirements, we are seeking an individual with good organizational and leadership qualities. Compensation arrangements are negotiable. Interested parties should submit letter of inquiry and/or resumes to Executive Director, Jeannette District Memorial Hospital, 600 Jefferson Ave., Jeannette, PA 15664.

New Jersey—Ancora—Immediate openings for staff psychiatrists and primary care physicians in 1100-bed JCAH and AMA accredited psychiatric hospital with three years approved residency training. Affiliated with Temple University Hospital department of psychiatry. Located thirty miles from Atlantic City and Philadelphia. Salary $28,722 to $40,713. Private practice after duty hours permitted. Liberal fringe benefits include professional liability, Blue Cross, Blue Shield, and life insurance. Write to Shao-Chi Yu, M.D., Ancora Psychiatric Hospital, Hammonton, NJ 08037, or call (609) 561-1700, ext. 343.

Pennsylvania and New Jersey Emergency Medicine positions available with fee-for-service group in suburban Philadelphia, central and eastern Pennsylvania, Pittsburgh, and northern and southern New Jersey hospitals. Physician directors also wanted. Send resume to: Northeast Emergency Medical Association, 500 Spruce St., Philadelphia, PA 19106; (215) 925-3511.

Psychiatrists and Physicians—Board certified or eligible, Pennsylvania license required. Immediate openings. Excellent opportunity to work in state hospital in developing new programs. Salary competitive. Limited housing available. Excellent fringe benefits. Call (412) 459-8000 or write Ray Bullard, M.D., Superintendent, or Peter Bishop, D.O., Assistant Superintendent, Torrance State Hospital, Torrance, PA 15779. An equal opportunity employer.

FP/GP and Internist—For family health center in north central Pennsylvania. Starting salary and fringe worth $52,500 with rapid advancement possible. Teaching opportunity and ownership option in FP residency. Rural area. Write Search Committee, Box 108, Elkland, PA 16920.

Emergency Physicians—Low volume quality care E.D. New hospital with spacious modern E.D. facilities. Rural, 80 miles from Pittsburgh. Join two career emergency physicians. American or comparable command of English. Complete fringes. Write Department 779, PENNSYLVANIA MEDICINE, 20 Erford Rd., Lemoyne, PA 17043.

Emergency Physicians—A multi-hospital group of emergency physicians seeks members for full-time positions at major hospital emergency departments in Philadelphia and other areas of Pennsylvania. In addition to full-time emergency physicians, a physician director is sought for each emergency department. The group encourages professional and administrative autonomy in its member physicians. Financial arrangements are fee-for-service with minimum guarantee. Emergency-oriented educational programs for physicians are maintained by the group at no charge to its members. Compensation ranges from $40,000 to $60,000 per year for 48 hours per week. Write: Department 650, PENNSYLVANIA MEDICINE, 20 Erford Rd., Lemoyne, Pa. 17043.

Family Physician—For group practice in greater Harrisburg, Pennsylvania. Three family practitioners and one pediatrician now here. At present there are 15,000 patients registered. Salary range in the 30s, lucrative fringe benefits. Send c.v. to Community Medical Associates, P.C., c/o Dr. Donald Spigner, PO Box 5142, Harrisburg, PA 17110; (717) 232-9971.

Emergency Room Physician—For private physician group, staffing ERs in Philadelphia and Delaware County. Must be Pennsylvania licensed. Forty hour week, competitive salary, paid malpractice, liberal fringe benefits, profit sharing. Send curriculum vitae to Emergency Medical Associates, Ltd., 15th and Upland Ave., Chester, PA 19013; (215) 874-8177.

House Staff Physician—Excellent opportunity for a *Pennsylvania licensed* physician to serve in a responsible position of a modern suburban Philadelphia, 286 bed hospital. JCAH accredited. $35,000 per year plus vacation, sick leave, paid pension plan, hospitalization, malpractice insurance, and disability insurance. Some evening and night duty required. For further information, contact John F. Dunleavy, Assistant Administrator, Holy Redeemer Hospital, Meadowbrook, PA 19046; telephone (215) 947-3000.

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Orthopedic Surgeon Wanted—Associate for well established Orthopedic Clinic in Eastern Pennsylvania. First year, salary plus percentage. Partnership after one year. Board eligibility required. No investment needed. Write Department 709, PENNSYLVANIA MEDICINE, 20 Erford Rd., Lemoyne, PA 17043.

POSITIONS WANTED

Internist—Penn Med graduate. Board eligible in internal medicine. Available July 1978 to associate with general internist or internal medicine group in Philadelphia area or South Jersey. (215) MI2-7960 after 6 p.m.

Weekend Coverage—Philadelphia University hospital internal medicine resident seeks quality physicians in eastern Pennsylvania who need weekend coverage. Intensive and ambulatory care experience. Excellent references. Reply Department 777, PENNSYLVANIA MEDICINE, 20 Erford Rd., Lemoyne, PA 17043.

University Radiologist—Desires private hospital practice. Experienced in ultrasound, nuclear medicine (certified ABNM) and administration. Prefer Philadelphia area. Write Department 778, PENNSYLVANIA MEDICINE, 20 Erford Rd., Lemoyne, PA 17043.

Certified Physician's Assistant—B.M.S.C. Desires position with medical center or rural physician providing primary care in Pennsylvania. For resume write or call Robert Pyle, 1028 Mell Ave., Clarkston, GA 30021; (404) 292-0494.

CONTINUING EDUCATION

Acid-Base and Electrolyte Seminar and Workshop—May 31 to June 2, 1978. Sheraton Hotel, Philadelphia. Sponsored by Hahnemann Medical College. AMA accredited. A. B. Schwartz, M.D., Program Director. For information write to Continuing Education, Hahnemann Medical College, 230 N. Broad St., Philadelphia, PA 19102; (215) 448-8266.

Prostaglandins in Cardiovascular and Renal Function—20th Annual A.N. Richard Symposium of the Physiological Society of Philadelphia and the Jefferson Medical College, May 8-9, 1978, Sheraton-Valley Forge Hotel, King of Prussia, PA. Dr. John Vane will deliver the A.N. Richards Lecture. Included among the 28 guest speakers are P. Needleman, J. C. McGiff, P. Hedqvist, J. Stein, J. Kokko. The symposium meets the criteria for 12 credit hours in Category 1 of the Physician's Recognition Award of the American Medical Association. Fees: Society members - free; nonmembers - $35; fellows, interns, residents - $15. For registration, write or phone Dr. Alexander Scriabine, Merck Institute for Therapeutic Research, West Point, PA 19486; (215) 699-5311.

FOR SALE

Pediatrician Closing Practice—Immaculate residence and seven-room office available immediately. Large custom-built brick and stucco, 5 years old, 5 bedrooms, 2 fireplaces, sonic alarms, intercom, fabulous kitchen, randon pegged floors or wall to wall carpeting even in finished basement, closets galore. Professional landscaping and more. Only $160,000. Mark A. Whitman, M.D., 1473 Fort Washington Ave., Ambler, PA 19002; (215) 643-5370.

MISCELLANEOUS

Biomedical Electronics Service—Repairs medical, laboratory, and other electronic equipment. Will install and remove x-ray equipment. Walker Electronics, 117 Sylvan Terrace, Harrisburg, PA 17104; telephone (717) 233-4716.

Space in Fort Washington-Ambler Area Professional Center—Specialties or general practice; 4 treatment rooms, laboratory, dark room, business office, waiting room, consultation room. Primary or secondary office, furnished or unfurnished, shared lease possible. (215) 646-1665.

NEW YORK UNIVERSITY
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Department of Pediatrics

announces

ANNUAL REVIEW OF
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This course reviews and updates knowledge of basic concepts and recent developments in selected areas of clinical pediatrics. It is designed for pediatricians and other physicians who care for infants, children, and adolescents. Special emphasis is given to practical considerations of diagnosis and management. Topics include cardiology, infectious diseases, nutrition, metabolism, and genetics. Material is presented through lectures, audiovisual aids, panel interactions, question and answer sessions, informal "shoptalk" luncheons, and an annotated bibliography. The text of key slides used to illustrate lectures will be distributed. There will be an opportunity for self-assessment of informational strengths and weaknesses through pre- and post-testing.

Tuition: $185

Accreditation: 14 hours credit in Category I for Physician's Recognition Award of the AMA

For information: Registration Department, NYUPGMS, 550 First Avenue, NYC, NY 10016; (212) 679-3200, Ext. 4038

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obituaries

• Indicates membership in the Pennsylvania Society at time of death.

• **Solomon M. Chartock,** Philadelphia; Hahnemann Medical College, 1931; age 72; died January 4, 1978. He had been chief of the department of cardiology at St. Luke's and Children's Medical Center and had practiced medicine in Philadelphia for 45 years.

• **William B. Carter,** Philadelphia; Temple University School of Medicine, 1916; age 87; died January 23, 1978. Dr. Carter had practiced medicine in Philadelphia for more than 50 years. He was the oldest living black graduate of Temple's School of Medicine, which awarded him a citation in 1968.

• **Samuel Chachkin,** Philadelphia; Temple University School of Medicine, 1943; age 59; died December 24, 1977. He was a specialist in general surgery and was chief of emergency services at Northeastern Hospital. He was also on the staffs of the Einstein Medical Center, Northern Division, and Frankford Hospital.

• **Tomas A. Duran,** Wilkes-Barre; Universidad de la Habana, Cuba, 1929; age 71; died December 28, 1977. He was well known for his work on diabetes. He had been a professor at the Medical College of Havana until 1960, when he began practice in Amarillo, Texas. He had practiced for 15 years in Wilkes-Barre, where he was on the staff of the Veterans Administration Hospital.

• **William C. Grasley,** State College; Hahnemann Medical College, 1943; age 59; died January 18, 1978. He was the team physician for Pennsylvania State University from 1962 to 1972, when he joined the staff of Centre Community Hospital. Dr. Grasley also served as an adjunct professor of applied physiology at the university, and was a past president of the Lycoming County Medical Society.

• **Chester E. Harris,** New Kensington; Tufts University School of Medicine, 1927; age 73; died December 20, 1977. He recently was honored for 50 years in the medical profession. Dr. Harris, a dermatologist and allergist, was a senior staff physician at Citizens General Hospital and a former staff member at Allegheny Valley Hospital.

• **John E. Hillig,** Wyomissing; Jefferson Medical College, 1962; age 43, died December 7, 1977. He had served as a staff physician in obstetrics and gynecology at Reading Hospital since 1969.

• **Paul G. L. Hoch;** Lower Burrell; University of Pittsburgh School of Medicine, 1916; age 85; died January 6, 1978.

• **Edgar K. Houck,** Reading; Hahnemann Medical College, 1927; age 76; died January 26, 1978. He was a former chief of orthopedics at the Community General Hospital in Reading and was honored in 1977 by the Berks County Medical Society for 50 years of medical service.

• **Albert E. Kratzer,** Emmaus; Temple University School of Medicine, 1936; age 68; died January 11, 1978. Dr. Kratzer, a past president of the Emmaus Board of Health, had practiced general medicine in Emmaus for 40 years.

• **Charles H. LaClair, Jr.,** Norristown; Jefferson Medical College, 1932; age 72; died January 9, 1978. Dr. LaClair began his otolarynogology practice in Norristown in 1940, following several years of practice in Philadelphia. He had served with the 38th General Hospital Jefferson Unit during World War II.

• **Edward H. Major,** Hazleton; University of Virginia School of Medicine, 1931; age 75; died December 24, 1977. While a surgeon in the Navy, Dr. Major helped to establish the eye department at the Navy Hospital in Key West, Florida. He later served on the staffs of Hazleton State General Hospital and St. Joseph Hospital. From 1952 to 1962 he was a clinical assistant on the attending staff of the Dr. Truman E. Boyes Clinic of New York Eye and Ear Infirmary and remained a life member of the infirmary staff.

• **Milton F. Manning,** Beallsville; University of Pittsburgh School of Medicine, 1912; age 90; died January 9, 1978. Dr. Manning had practiced general medicine in Beallsville for 64 years and had been the oldest member of the Washington County Medical Society.

• **Thomas W. McCreary,** Beaver, University of Pennsylvania School of Medicine, 1926; age 77; died February 2, 1978. He was a past president of the Pennsylvania Medical Society and the Beaver County Medical Society and was a member of the House of Delegates to the AMA. He opened the first complete clinical pathology laboratory in Beaver County in 1929 at the Rochester General Hospital. In addition to serving that hospital as pathologist, he was staff pathologist at Providence Hospital, Beaver Falls, and the Ellwood City Hospital. He retired from active practice in 1971.

• **George H. Miles,** Altoona; University of Pennsylvania School of Medicine, 1927; age 80; died January 7, 1978. He had been a surgeon with the Pennsylvania Railroad and the Pennsylvania Coal and Coke Corporation and had served on the staffs of the Altoona, Mercy, and Altoona VA hospitals.

• **David R. Morgan,** Edwardsville; Jefferson Medical College, 1916; age 90; died January 15, 1978. He was a professor emeritus of Jefferson Medical College and retired chief pathologist at St. Luke's and Children's Medical Center in Philadelphia.

• **Paul F. Polentz,** Scranton; Temple University School of Medicine, 1928; age 74; died January 21, 1978. Dr. Polentz was a founder of the American Diabetes Association and was an advisor in the development of Boston's Jocelyn Diabetes Clinic. He had been chief of medicine at Scranton State Hospital for 20 years and was on the staffs of Mercy Hospital and Community Medical Center.

• **Sava Radisavljevic,** Pittsburgh; University of Belgrade, Yugoslavia; age 38; died December 19, 1977. He was a pathologist and director of laboratories at Connellsville State General Hospital and had been chief of medicine at the Hospital Center of Taza in Morocco from 1966 to 1971.

• **Walter F. Rongaus,** Donora; Jefferson Medical College, 1936; age 66; died January 21, 1978. He had been a member of the medical staff of Charleroi Division of Mon Valley Hospital for 40 years.

• **John M. Skirpan,** Arlington, Virginia; Chicago College of Medicine and Surgery, 1914; age 86; died December 13, 1977. Dr. Skirpan had practiced medicine in Monessen for 52 years.

• **Abraham L. Waldman,** Norristown; Temple University School of Medicine, 1940; age 71; died January 24, 1978. He was senior physician at Norristown State Hospital, director of the Reception Center of Philadelphia General Hospital, and director of the Eastern Health Center.

• **Marion West,** Philadelphia; Medical College of Pennsylvania, 1932; age 77; died December 3, 1977.

• **Arthur C. F. Zobel,** Johnstown; University of Pennsylvania School of Medicine, 1922; age 79; died January 11, 1978. He had begun his medical practice in Johnstown in 1927.

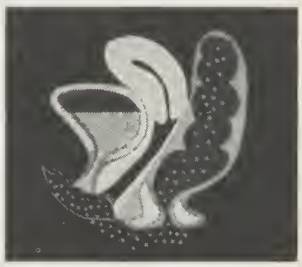
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For recurrent attacks of urinary tract infection in women

Bactrim™ DS Double Strength Tablets

Each tablet contains 160 mg trimethoprim and 800 mg sulfamethoxazole.

Just one tablet b.i.d. for 10 to 14 days



- Action at urinary/vaginal/lower bowel sites helps eliminate reservoirs of infecting organisms
- Distinctive antibacterial action plus wide spectrum helps eradicate recurrent UTI
- Low incidence of bacterial resistance in community practice
- Convenient *b.i.d.* dosage provides day-and-night antibacterial control
- Contraindicated during pregnancy and the nursing period. During therapy, maintain adequate fluid intake; perform CBC's and urinalyses with microscopic examination.

Before prescribing, please consult complete product information, a summary of which follows:

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli, Klebsiella-Enterobacter, Proteus mirabilis, Proteus vulgaris, Proteus morganii.* **It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination.** *Note:* The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

Also for the treatment of documented *Pneumocystis carinii* pneumonitis. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.

The recommended quantitative disc susceptibility method (*Federal Register,* 37:20527-20529, 1972) may be used to estimate bacterial susceptibility to Bactrim. A laboratory report of "Susceptible to trimethoprim-sulfamethoxazole" indicates an infection likely to respond to Bactrim therapy. If infection is confined to the urine, "Intermediate susceptibility" also indicates a likely response. "Resistant" indicates that response is unlikely.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers; infants less than two months of age.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

Urinary Tract Infections: Usual adult dosage—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days.

Recommended dosage for children—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. A guide follows:

Children two months of age or older:

Weight		Dose—every 12 hours	
lbs	kgs	Teaspoonfuls	Tablets
20	9	1 teasp. (5 ml)	½ tablet
40	18	2 teasp. (10 ml)	1 tablet
60	27	3 teasp. (15 ml)	1½ tablets
80	36	4 teasp. (20 ml)	2 tablets or 1 DS tablet

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	½ the usual regimen
Below 15	Use not recommended

Pneumocystis carinii pneumonitis: Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: *Double Strength (DS) tablets,* each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100. *Tablets,* each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40, available singly and in trays of 10. *Oral suspension,* containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole, fruit-licorice flavored—bottles of 16 oz (1 pint).

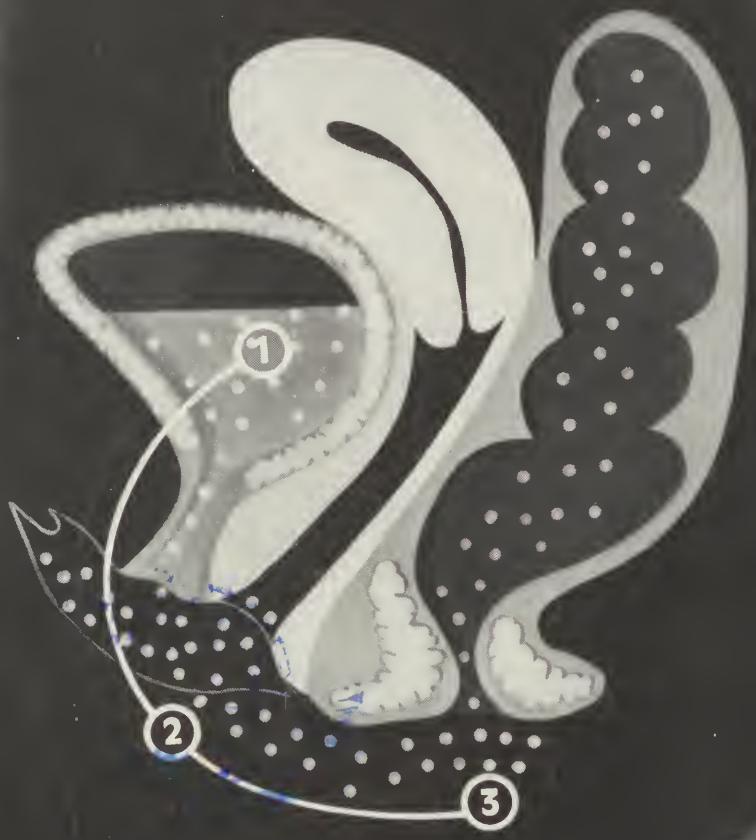
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Please see back cover.

Her next attack of cystitis may require

the Bactrim™ 3-system counterattack



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Bactrim has shown high clinical effectiveness in recurrent cystitis as a result of its wide spectrum and distinctive antimicrobial action in the urinary, vaginal and lower intestinal tracts.

The probability of recurrent urinary tract infection appears to be enhanced by the establishment of large numbers of *E. coli* or other urinary pathogens on the vaginal introitus. The trimethoprim component of Bactrim diffuses into vaginal fluid in effective concentrations, thus combating migration of pathogens into the urethra.

Studies have shown that Bactrim acts against *Enterobacteriaceae* in the bowel without the emergence of resistant organisms. Thus, Bactrim reduces the risk of introital colonization by fecal uropathogens. It has *no* significant effect on other normal, necessary intestinal flora.

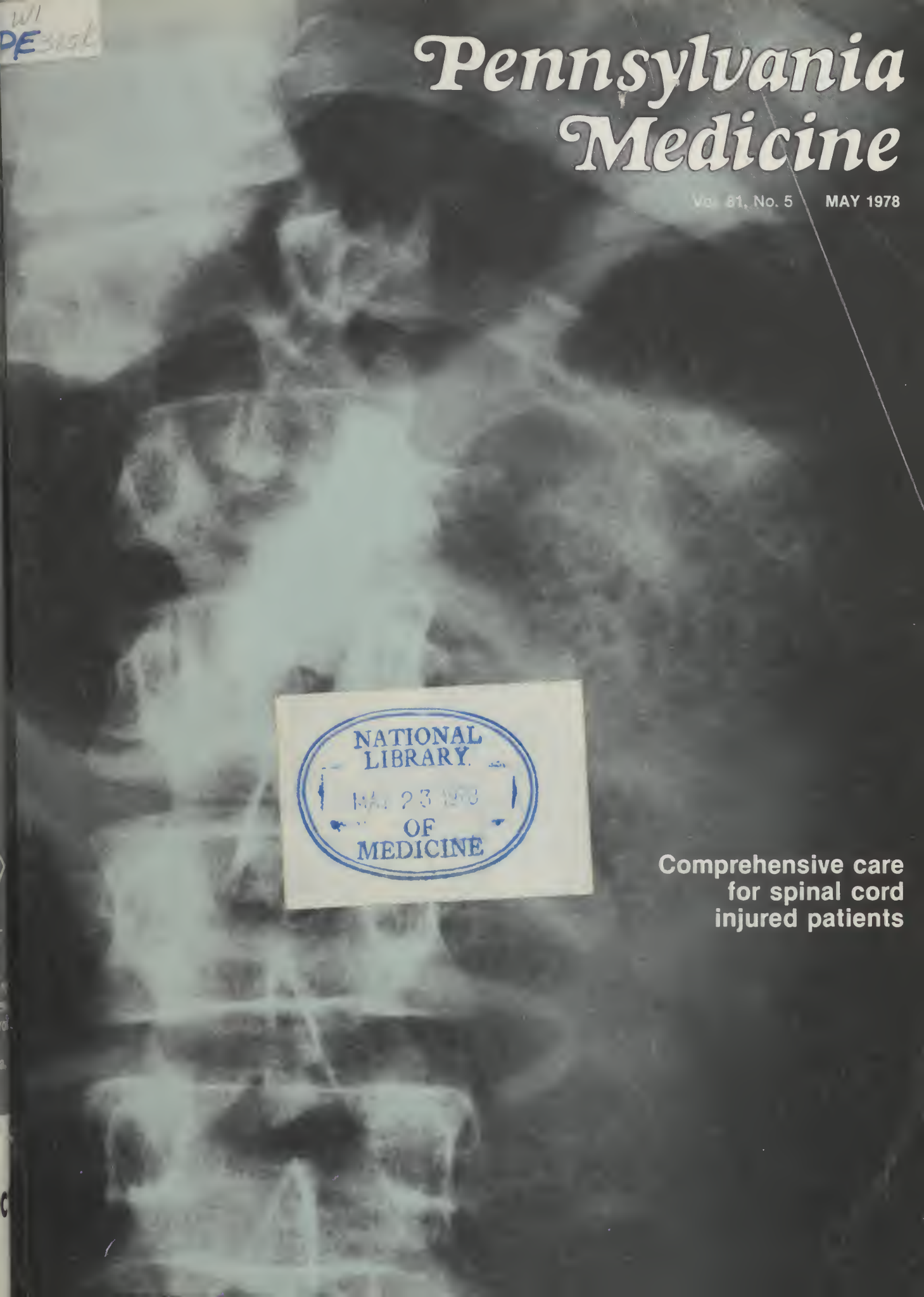
Bactrim fights uropathogens in the urinary tract/vaginal tract/lower intestinal tract

Please see reverse side for summary of product information.

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Pennsylvania Medicine

Vol. 81, No. 5 MAY 1978



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MAY 23 1978
OF MEDICINE

Comprehensive care for spinal cord injured patients



VALIUM®(diazepam)

Before prescribing, please consult complete product information, a summary of which follows:
Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).
The effectiveness of Valium in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the indi-

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.
Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**
Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.
Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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Nutley, New Jersey 07110

medigram

MEDICAL ASSISTANCE FAILURE REVEALED IN BUDGET PLANS

John V. Blady, M.D., Society president, criticized Department of Public Welfare budget plans in a special letter to the Legislature April 19. "The current program," he said, "encourages the most expensive kind of medical care--that delivered in a hospital...and may place additional burdens on the people it is designed to serve."

The letter was accompanied by a paper outlining the Society's position and making the following charges:

DPW and the Legislature have failed to provide an efficient medical assistance program. Poor people must be assured of the same opportunity to receive quality medical care as others in the community.

Abuse of the drug program is a problem with which the department has not dealt.

Program administration should be handled by Pennsylvania Blue Shield for effective utilization review and quality control.

The Department of Health should be the state agency responsible for supervising quality, availability, and utilization of medical care. DPW's responsibility should be limited to eligibility determination, enrollment, and welfare related functions.

The present program is a failure. Many physicians do not participate because of cumbersome administration and grossly inadequate reimbursements.

STATE MEDICAL BOARD HAS FULL TIME EXECUTIVE

The first full time chief executive officer has been appointed for the State Board of Medical Education and Licensure. The appointment of Clayton Scott to the post was announced by James G. Krause, commissioner of professional and occupational affairs, and was effective April 3. Two full time attorneys also have been added to the medical board staff. In addition, plans were announced in April for a six-week training program this summer at Shippensburg State College for a staff of 12 medical investigators whom the board will hire immediately. The State Society brought suit against the Commonwealth January 11, 1978 to force the release of over $2 million in licensing fees so that the medical board could enforce the Medical Practice Act. Settlement negotiations on the suit continue with the State Department of Justice.

PMSLIC INSURING NEARLY 5,000

The Pennsylvania Medical Society Liability Insurance Co. has issued policies to 4,371 members of the State Society since January 1, 1978 and is processing an additional 333 applications. This information was part of a report delivered at the 1978 Officers' Conference by David S. Masland, M.D., Carlisle, PMSLIC president. Of the policies already issued, 2,883 are occurrence and 1,430 are claims made policies. An additional 416 policies have been issued to partnerships or corporations.

HOSPITALS BRING SUIT TO STOP REGULATIONS

The Hospital Association of Pennsylvania and 21 hospitals filed suit in Commonwealth Court April 12 asking that the Pennsylvania Department of Health and Secretary of Health Leonard Bachman, M.D., be enjoined from implementing revised regulations for hospitals. The regulations were published in final form in the Pennsylvania Bulletin December 10, 1977 after years of study and revision, and are to become effective June 10, 1978. A hearing was held April 19 on a request for a temporary injunction. No decision on the request was handed down at press time.

DR. ROWLAND DELEGATE IN HOSPITAL ASSOCIATION

George A. Rowland, M.D., Millville, chairman of the Society's Board of Trustees, has been selected physician delegate of the House of Delegates of the American Hospital Association. He will represent physicians from New Jersey, New York, and Pennsylvania for a two-year term beginning January 1, 1979.

INSURANCE COMPANY IN NEW OFFICES

The Pennsylvania Medical Society Liability Insurance Co. is located in new offices in Philadelphia. The address is: Suite 1669, Suburban Station Building, 1617 John F. Kennedy Blvd., Philadelphia, PA 19103; (215) 568-5777.

STATE MEDICAL BOARD REVOKES LICENSE

The State Board of Medical Education and Licensure April 19 revoked the license of Peter T. DeMarco, M.D., of Norrisville, Bucks County. The action awaits the approval of the Justice Department. An appeal is expected.

Dr. DeMarco's New Jersey license was revoked January 12 after 92 patients treated at his Pine Hill, NJ office became ill with hepatitis. Two of them died. He moved his office to the Pennsylvania location after his New Jersey license was suspended in July 1976. In an independent action the Department of Health ruled in March that the supplies of Procaine PVP, the controversial drug with which Dr. DeMarco injected his patients, be destroyed.

MEDICAL PROTECTIVE FILES FOR INCREASE

The Insurance Department has announced it will hold formal hearings on the request by Medical Protective Co. for a $3.8 million increase in premiums for professional liability insurance. The request amounts to a 40 percent premium increase for some 6,000 physicians covered by the company.

PMS EXPANDS SERVICES FOR SPECIALTIES

The Pennsylvania Chapter of the American Academy of Pediatrics and the Pennsylvania Academy of Ophthalmology and Otolaryngology are the latest specialty societies contracting for services with the PMS Department for Specialty Societies. Eleven specialty societies currently are served by the department. More news about specialty societies appears on pages 10 and 11.

SUPREME COURT UPHOLDS HEALTH PLANNING ACT

The U. S. Supreme Court April 18 upheld the constitutionality of the National Health Planning and Resources Development Act of 1974. It refused to hear an appeal from the decision of a three judge federal court in North Carolina which held that Congress had the authority to require states to adhere to federal guidelines in order to receive federal money for health care. The suit was brought originally by the state of North Carolina, which was joined by the state of Nebraska and the American Medical Association.

Pennsylvania Medicine

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Cost containment committee endorses national guidelines

Members of the Pennsylvania Voluntary Health Care Cost Containment Committee agreed in March to ask Pennsylvania's hospitals to cooperate voluntarily in an organized program of cost containment designed to hold down the rate of increase in hospitals' expenses statewide by two percentage points during the next year.

The committee, organized by the Pennsylvania Medical Society and the Hospital Association of Pennsylvania (HAP), became autonomous with the election of Sharon General Hospital President Eugene J. O'Meara as chairman and Henry H. Fetterman, M.D., of Allentown, as vice chairman. Both PMS and HAP will supply staff resources for the committee, as will the various organizations and institutions in the group's membership.

At its meeting, the committee reviewed and endorsed a 15-point cost containment program developed by a national committee. A major aspect of the national program is an effort to reduce the rate of annual increase in hospitals' expenses for the next two years by two percentage points per year.

Also adopted was a plan for provisional certification of hospitals. According to O'Meara, the state's 264 short-term hospitals will be encouraged to apply for the certification, specifics of which include:

- Adoption by hospital board and medical staff of resolutions of support for the program;
- Submission to the voluntary state committee of figures on total operating expenditures for fiscal years 1976-1979;
- Submission of regular reports indicating that operating and capital budgets are being reassessed for possible further reductions consistent with sound medical practice;
- Submission of specific examples of cost containment projects for the edification of other institutions and the public;
- Commitment by the hospital to explore all reasonable cost containment measures which might be taken by the hospital or jointly with other institutions.

O'Meara said suppliers of goods and services to hospitals also will be asked to help make the program a success by attempting to hold down their prices. In noting that patient demand for hospital services will have to be tempered increasingly by cost considerations, he predicted even more emphasis on non-institutional care, such as outpatient care and home health services.

Subcommittees were appointed to develop plans for data gathering, promotion and communications, capital costs, and administration needed to assist hospitals which are unable to meet fiscal guidelines. Hospitals will be asked to apply for full certification under the cost containment program when these plans are completed.

Members of the Pennsylvania Voluntary Hospital Cost Containment Committee are:

Edward A. Battisfore, general manager of central area, Bell of Pennsylvania; Irvin Berland, administrator, Parkview Hospital, Philadelphia; William E. Bradfield, assistant vice president of group administration, Provident Mutual Life Insurance Company of Philadelphia; H. Robert Cathcart, president, Pennsylvania Hospital, Philadelphia; John W. Clem, executive director, Health Systems Agency, Inc., Pittsburgh; also

Eli S. Egert, president, Penn Group Health Plan, Inc., Pittsburgh; Henry H. Fetterman, M.D., Allentown; Henry E. Fish, president, American Sterilizer Co., Erie; Howard Gindele, president, Blue Cross of Western Pennsylvania, Pittsburgh; H. Donald Hamilton, administrator, Easton Hospital, Easton; Webb S. Hersperger, M.D., Carlisle; Paul F. Kase, M.D., Harrisburg; James Mahoney, executive vice president, Pennsylvania AFL/CIO, Harrisburg; Monsignor Andrew J. McGowan, rector, Saint Pius X Seminary, Dalton; Anthony A. Minissale, D.O., Philadelphia; also

Eugene J. O'Meara, president, Sharon General Hospital, Sharon; Richard D. Rife, president, Capital Blue Cross, Harrisburg; Robert E. Rinehimer, president, Pennsylvania Blue Shield, Camp Hill; Charles S. Ryan, M.D., director of health and safety, Sun Company, Radnor; Edward J. Stemmler, M.D., dean, University of Pennsylvania School of Medicine, Philadelphia; Joseph Stowell, M.D., Altoona; Paul G. Wedel, president, Lancaster General Hospital, Lancaster; C. Robert Youngquist, executive director, Magee-Women's Hospital, Pittsburgh; Robert A. Zelten, associate professor of insurance and health care systems, University of Pennsylvania, Philadelphia.

New PSRO regulation permits data disclosure

Professional Standards Review Organizations (PSROs) are authorized to disclose certain health care data if individually identifiable patient records are not disclosed, according to a regulation published in January by HEW's Health Care Financing Administration.

The regulation gives PSROs permission to disclose data or information that was legally available to the public before it was received by the PSRO. PSROs may also disclose summary statistics derived from the Uniform Hospital Discharge Data Set (UHDDS), a collection of information about patients and their use of hospital services. No individual may be identifiable in the information released.

Society's environmental awards presented at conference

Frank E. Masland, Jr., of Carlisle, and the Lehigh River Restoration Association, Inc., of Walnutport, received Pennsylvania Medical Society Environmental Improvement Awards during the 1978 Officers' Conference banquet April 12 at the Hershey Motor Lodge, Hershey.

Masland received the individual award for his continuing efforts in creating park lands, securing protection for nature preserves and wildlife, and obtaining national historic and scientific landmark status for several sites in Pennsylvania.

He has served on local, state, national, and international levels: as an active participant in community environmental programs; as chairman of the Governor's Conference on Environment in 1966 and 1969 and director of the Pennsylvania Forestry Association; as chairman of the National Park Service Committee to Consider National Park Criteria; and as a member of the advisory board to the Secretary of the Interior and a representative of the Secretary on several expeditions.

The volunteer agency environmental award was presented to the Lehigh River Restoration Association in recognition of its work to improve the quality of the waters of the Lehigh River and its tributaries.

Since 1967 the group has worked to rehabilitate approximately 20 miles of the river in Carbon, Lehigh, and Northampton counties. Members have assisted communities in obtaining financing for purchase and development of the area; have worked to alleviate mine acid and waste water treatment problems; and have attempted, through clean up and stocking programs, to assure the quality of resources.

Surgeons meet on cancer

Cancer treatment was the primary topic of discussion at the annual meeting of the Southwestern Pennsylvania Chapter of the American College of Surgeons on April 12 in Pittsburgh.

Guest speaker Richard L. Varco, M.D., F.A.C.S., of the University of Minnesota, set the pace for discussion with his talk on "Cancer: The Surgeon's Dilemma."

Other speakers were George A. Higgins, Jr., M.D., of the Veterans Administration Hospital in Washington, D.C., on the biology of cancer; Theodor B. Grage, M.D., University of Minnesota, on adjuvant chemotherapy; Bernard Roswit, M.D., of the VA Hospital in Bronx, New York, on radiotherapy; and Paul B. Chretien, M.D., of the National Cancer Institute, on immunotherapy.

Benjamin Rush awardees honored

A lady they call "Mama" and a Mennonite church group received Benjamin Rush Awards from the State Society during the 1978 Officers' Conference banquet held April 12 in Hershey.

Mrs. Romeo Franchini, known affectionately as "Mama" among employes and residents of the John J. Kane Memorial Hospital in Pittsburgh, has contributed more than 7,500 hours of service to the chronic care and geriatric facility.

Despite her age (74) and her own chronic arthritis, "Mama" spends at least one day a week at Kane and participates several times a month in special recreation programs, at which she often appears in costume to entertain patients with her dance routines.

The Johnstown Area Mennonite Disaster Service, which received the organizational Benjamin Rush Award, answered a call for help from Johnstown flood victims on July 21, 1977 and is still helping area residents.

Specializing in volunteer manpower in time of disaster, the group organized nearly 300 persons per day to clean up and to provide services for disaster victims. Beginning in September 1977, a corps of craftsmen was organized to begin rebuilding the area; well into 1978 the group has continued to rebuild and to issue financial grants to needy victims.

Robert Poole, III, M.D., West Chester, chairman of the State Society's Council on Professional Relations and Services, presented the awards at the Officers' Conference banquet.

Regulation controls medicare kidney program

HEW's Health Care Financing Administration (HCFA) has issued a final regulation to make certain that it pays for care given to patients served by medicare's kidney disease program on a basis that is closely related to the cost of the care.

The regulation, published December 30, 1977 and effective immediately, requires free-standing renal dialysis facilities to furnish information about their costs to HCFA. HCFA will use the information to set appropriate reimbursement rates and to determine whether requests for adjustment of existing reimbursement rates are justified.

The regulation also formalizes HCFA's authority to make studies of services provided by physicians treating kidney transplant patients or those on maintenance dialysis. The information obtained will help determine how much medicare will pay physicians for these services.

Dauphin County society successful in television debut



The Dauphin County Medical Society joined forces with the Public Broadcasting System's Hershey affiliate, WITF-TV, on March 23 for the premiere of *MediCall,* a program designed to give the public a chance to ask physicians questions about health maintenance and preventive medicine. WITF-TV serves a 16-county viewing area in central Pennsylvania.

The monthly series features a panel of physicians who answer questions, a 15-phone bank monitored by volunteers from the Dauphin County Medical Society Auxiliary and coordinated by Mrs. Stephen Herceg, and viewers' questions on topics ranging from cardiovascular disease to adolescent sexual behavior.

The March 23 show on heart disease, which continuously drew questions on the 15 phones, featured panel members George R. Moffitt, Jr., M.D., a cardiologist at Harrisburg Hospital; Donald Durbeck, M.D., associate in the division of cardiovascular diseases at Polyclinic Medical Center, Harrisburg; and Arthur Liedtke, M.D., associate professor of medicine at Hershey Medical Center.

MediCall's April 24 program on teenage sexuality drew viewer questions on adolescent behavior, pregnancy, venereal disease, and drug abuse.

On May 22 at 8 p.m., viewers and doctors will have a chance to air their complaints about the medical community. Future topics will be determined by a steering committee which reviews suggestions submitted by physicians and other viewers.

Blue Shield rates same for many subscribers

For the first time since the early 1970s, Pennsylvania Blue Shield says it will not ask for a rate increase this year for half its subscribers. The decision affects individual subscribers and those in groups of less than 100 members, a total of three million people.

According to Blue Shield, a rate increase was not necessary because:

- Many unnecessary medical services have been eliminated through cost control programs, such as utilization review;
- The Plan trimmed administrative costs;
- The rate of increase of new claims slowed to five percent, compared to 13 percent in 1977;
- Eighty-seven percent of the state's practitioners are participating physicians and accept the usual, customary, and reasonable reimbursement charge as payment in full.

State Society members who are insured by the Workmen's Compensation savings classification plan of Casualty Reciprocal Exchange will be called on by the company's field auditors before May 31. Ready availability of necessary records or prompt return of voluntary reports will facilitate return of the Dodson Insurance Group yearly rebate to Society members.

Internists meet in Hershey

The 116th annual meeting of the Pennsylvania Society of Internal Medicine is scheduled for Friday, May 19 to Sunday, May 21, 1978 at Hotel Hershey.

The society's annual business meeting will begin at 4 p.m. on Friday and will be followed by a dinner at 7:30 p.m. with guest speaker James Collins, M.D., trustee of the American Society of Internal Medicine.

Beginning Saturday, May 20 at 8:30 a.m., the annual program will feature guest speakers Duncan Neuhauser, associate professor of health services administration at Harvard University School of Public Health; Samuel P. Martin, M.D., executive director of the Leonard Davis Institute of Health Economics at the University of Pennsylvania; and James Neely, president of the Hospital Association of Pennsylvania. Dr. Neuhauser will speak also at the annual banquet and installation of officers on Saturday at 7:30 p.m.

A Sunday morning "Breakfast with the Professors" will begin at 8:30 a.m. Sol Sherry, M.D., chairman of the department of medicine at Temple University School of Medicine, will discuss "Togetherness and Organized Internal Medicine."



Gerald Andriole, M.D., newest member of Board of Trustees

He practices what he believes. That's why Gerald L. Andriole, M.D., Hazleton urologist, has been occupied since last October as a member of the State Society's Board of Trustees.

Wrestling with the intricacies of representing the medical profession has become a complex and time consuming job, but to Gerald Andriole it is a personal opportunity to extend his belief that "if you're a doctor, you should join organized medicine, become knowledgeable concerning the issues involving the practice of medicine, and participate in medical society activities."

Dr. Andriole was elected trustee and councilor for the Twelfth District (Bradford, Luzerne, Sullivan, Susquehanna, and Wyoming Counties) by the 1977 House of Delegates. He replaced Orlo G. McCoy, M.D., of Canton, who retired after more than six years on the Board.

Dr. Andriole brings to office a conviction that physicians "must be constantly alert to and on guard against the various nostrums prescribed by the 'do gooders' in government, and be able to prevail when government solutions are not in the best public interest. This means we must initiate actions to assure quality medical care to all people at a cost which is affordable.

"We can accomplish this if we aggressively 'market our product' to the public. Our long years of individual training and the high professional standards established and maintained by organized medicine put physicians in a position of eminence to solve health care problems. In addition, polls continue to verify that we maintain a high level of public trust. We are in a position, therefore, to speak out on health issues, and provide as a backdrop medical triumphs of the past, without being pre-empted by government. Initially, we must begin to act on the problems instead of reacting after questionable solutions have been presented by others."

Dr. Andriole believes there is a project at hand which the profession can undertake immediately to emphasize its leadership position. "Every physician," he suggests, "should begin to practice preventive medicine, and this undertaking should be publicized widely. After all, disease prevention and cutting health care costs are the center of national attention today. By personal example and in our role as teachers of our patients, we can demonstrate that changes in lifestyle can prevent illness, and prevention of illness will deter the escalation of health care costs."

Gerald Andriole earned his degree in medicine at Loyola Medical School in Chicago in 1948, after completing undergraduate studies at the University of Scranton. He interned at Scranton State Hospital.

He served as a captain in the U.S. Army Medical Corps from 1951 through 1953, after beginning his residency in urology at Metropolitan Hospital in New York. Dr. Andriole completed his residency at Rhode Island Hospital in Providence and Millard Fillmore Hospital in Buffalo, and

then taught for a year at the New York Medical College.

In 1955 he entered the private practice of medicine in Hazleton, where he is chief of urology at St. Joseph's Hospital and a staff member at Hazleton State General Hospital. He has served as chief of the medical staff at both hospitals and is a consultant at the White Haven School and Hospital.

Gerald Andriole joined the Luzerne County Medical Society in 1955 and has been active in the Hazleton Branch, which he currently serves as president. He has been a delegate from the Luzerne County Medical Society to the PMS House of Delegates since 1974, and has served the State Society as a member of the Council on Education and Science, the Benjamin Rush Awards Committee, and the Council on Professional Relations and Services.

Dr. Andriole was board certified in urology in 1959, and is a member of the American Urological Association and the Mid Atlantic Urology Association. In addition he is a fellow of the American College of Surgeons.

He and his wife, Irene, have four sons and a daughter. In this medically oriented family, two of the sons are in medical school, one of whom will graduate from Jefferson in June 1978. Another son is in law school and the fourth is in college. High school currently occupies their daughter. Mrs. Andriole has been active for many years in the Pennsylvania Medical Society Auxiliary.

Gerald Andriole brings to the Society's Board of Trustees the knowledge gained from more than 20 years in the private practice of medicine, in service to his community through civic organizations, and in medical organization experience through county and state medical society activities. He believes the function of the Board of Trustees is to consolidate the members in implementing the policies and purposes of the State Society to the benefit of the profession and the people of Pennsylvania.

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PAFP holds thirtieth annual convention

The 30th annual convention and scientific assembly of the Pennsylvania Academy of Family Physicians is scheduled for Monday, May 22 through Friday, May 26, 1978 at the Tamiment Resort and Country Club, Tamiment.

The meeting will combine business sessions with lectures on medicine. House of Delegates sessions will be held from 2:30 to 5:00 p.m. on Monday and Tuesday and will be followed by reference committee meetings.

The president's reception and annual dinner will be held at 6:30 p.m. on Thursday, May 25.

Among those scheduled to speak during the five-day meeting are: Charles Shuman, M.D., professor of medicine at Temple University School of Medicine, on diabetes; David P. Connolly, M.D., chairman of the department of surgery at St. Margaret's Hospital in Pittsburgh, on office proctology; William W. Fox, M.D., associate professor of pediatrics at Children's Hospital of Philadelphia, on newborn pulmonary problems; David Shearer, M.D., coordinator of internal medicine at York Hospital, on thyroid disease; Charles O'Brien, M.D., associate professor of psychiatry at the University of Pennsylvania School of Medicine, on depression; and Robert A. Zimmerman, M.D., of Penn's department of radiology, on computerized tomography.

Also speaking are Philip Nelson, M.D., chairman of obstetrics and gynecology at Williamsport Hospital; and David Finn, M.D., and John Burks, M.D., of the department of cardiopulmonary medicine at Williamsport Hospital.

Academy registration opens at 2 p.m. on Sunday, May 21. The registration fee for academy members if $25; nonmembers must pay $40; and there is no fee for medical students, interns, and residents.

Registration for the meeting may be made through PAFP, 5600 Derry St., Harrisburg, PA 17111.

Ivy Society holds residents meeting



Physicians attending the recent residents meeting of the Robert H. Ivy Society are (l. to r.): Raymond Joehl, M.D., resident in plastic surgery at Hershey Medical Center; Stephen Herceg, M.D., of Harrisburg; Robert Davis, M.D., of York, program director; and John Schantz, M.D., senior resident in plastic surgery at Hershey.

The Annual Residents Scientific meeting of the Robert H. Ivy Society of Plastic and Reconstructive Surgeons was held March 11 at the Hershey Medical Center. Robert M. Davis, M.D., vice president, chaired the meeting.

Residents in plastic surgery and general surgery and medical students associated with plastic surgery training programs presented abstracts of scientific papers. The papers were judged for preparation, presentation, and use of illustration or audio-visual aids.

The three winners were Richard Dabb, M.D., University of Pennsylvania, for his paper, "Free Flap Reconstruction for Romberg's Disease"; Jane Petro, M.D., Hershey Medical Center, for her paper, "Ocular Injuries Associated with Periorbital Fractures"; and Barry Shesol, M.D., University of Pennsylvania, for his paper, "Lymphnode Function After Heterotopic Transplantation."

Gary Price, B.S., received honorable mention for his presentation of "Acute and Delayed Effects of Tourniquet Ischemia of Subfacial Pressures of the Subhuman Primate Limb."

Following the meeting a banquet was held for all participants at the Hotel Hershey.

Effective May 13, 1978 the telephone number of the Pennsylvania Medical Society is (717) 763-7151 Please correct your records.

Emergency physicians meet on health care services

Representatives from the Pennsylvania Chapter of the American College of Emergency Physicians (PaACEP), the Pennsylvania Emergency Health Services Council (PEHSC), and the Pennsylvania Department of Health met at Pennsylvania Medical Society headquarters in March.

Purpose of the meeting was to share ideas and mutual concerns about emergency health care in Pennsylvania.

Joel Grottenthaler, executive director for PEHSC, and William Dethlefs, director of the division of emergency health services of the Pennsylvania Health Department, were present to explain their respective operations as related to the overall emergency health system. Grottenthaler also explained the procedures for applying for federal grants under the Emergency Medical Systems Act of 1973.

PaACEP representatives from five regional EHS councils discussed mutual problems encountered in representing the interests of emergency physicians on these councils. The five regional councils represented were Southeastern EHS Council, Eastern Pennsylvania Emergency Medical Services Council, Susquehanna Emergency Health Services Council, Emergency Medical Services Institute, and Emergency Medical Services Council of Northwestern Pennsylvania.

William W. Resinger, M.D., PaACEP president, and Joseph A. Fortuna, M.D., president elect, presided at the meeting sponsored by PaACEP.



Dr. Resinger and Dr. Fortuna

New drug formulary issued

The State Health Department has issued a new, finalized generic drug formulary that, according to Health Secretary Leonard Bachman, M.D., will result in greater savings for citizens of Pennsylvania.

Copies of the formulary will be mailed to all registered pharmacies in the state, and will be available to medical practitioners on request.

For copies of the formulary or the consumer guide write to Bureau of Health Communications, PO Box 90, Harrisburg, PA 17120 or phone the toll-free State Health Line at (800) 692-7254.

Urologists hold annual meeting at Hotel Hershey

The Urological Association of Pennsylvania will hold its annual meeting June 9-11, 1978 at the Hotel Hershey. Guest speakers for the three-day meeting are Willard Goodwin, M.D., professor of urology at the University of California at Los Angeles; David Culp, M.D., professor of urology at the University of Iowa; and William Fry, Ph.D., chairman of the department of Russian at Franklin and Marshall College, Lancaster.

Friday's program, sponsored by the Hershey Medical Center, will include Grand Rounds and a pyelogram conference. Participants are urged to bring their difficult cases for consultation with the guest professors.

Saturday will begin with morning lectures and a business meeting. That evening, William Fry will present a program entitled "Your Pennsylvania Dutch Heritage" at the annual banquet.

The program concludes on Sunday morning with a session on third party problems.

More information is available from the PMS Department for Specialty Societies.

Surgical specialists meet

The Pennsylvania Society of Colon and Rectal Surgery will meet on May 12, 1978 at the Union League in Philadelphia.

The society's executive council will meet at 4:30 p.m., after which a fellows' meeting will be held. Presenting a medical program at that meeting are: Frank Theuerkauf, M.D., of Erie; and Robert Braglia, M.D., Indru Khubchandani, M.D., James Sheets, M.D., John Stasik, M.D., Howard Trimpi, M.D., Guy Kratzer, M.D., and Mahendra Matta, M.D., all of Allentown.

Physician beware: due process may depend on state

Fred Speaker, Esq.

Forces fighting for physicians' rights suffered another loss last year in a federal court in eastern Pennsylvania.[1] A general surgeon, not reappointed to the hospital medical staff, sought a permanent injunction against the hospital for its denial of due process in deciding not to retain him. The federal district court disagreed with a previous major Pennsylvania decision[2] and held that the physician could not prevail under the Civil Rights Act[3] because there was no state action taken against him.

It is a basic rule that there must be state action in order to win a "1983" claim. Although there have been several cases in the past fifteen years against private hospitals in which state action was found to have existed,[4] the definite trend in recent years has been toward a contrary result.[5]

Mr. Speaker is a partner in the law firm of Pepper, Hamilton & Scheetz, which serves as the Society's legal counsel.

In this case, the physician claimed that there was state action because the hospital had received some $1.1 million—or just under ten percent of its total construction costs—under the Hill-Burton Act.[6] The Court stated that there are two conditions under which state action could be found: (1) so close a connection between the state and the action that the action can be fairly treated as that of the state itself; or (2) the state and the hospital have entered into a symbiotic relationship. The Court went on to say:

> . . . since we do not believe that the receipt of Hill-Burton funds created a "symbiotic relationship" between the Hospital and the Commonwealth, it was necessary for the plaintiff to establish that the Commonwealth participated in the challenged activity. Plaintiff offered no evidence, however, that the Commonwealth in any way fostered or encouraged *via* statute, regulation or otherwise, the termination by defendants of his staff privileges and lease.[7]

Thus once again a physician loses, not because his rights were not abused but because of the type of hospital in which he had privileges.



In response to an American Medical Association estimate that one of five Americans has a hidden medical problem, ranging from diabetes to allergies to medications, the Medic Alert Foundation International has stepped up efforts to promote membership in Medic Alert.

Members are issued a Medic Alert bracelet or necklace on which is engraved the hidden medical condition, an identification number, and a 24-hour-a-day emergency telephone number. Within seconds of receiving a call, emergency operators can relay information from a computerized data base that is updated annually.

Medic Alert conducts ongoing education and information programs. The professional education program teaches medical and emergency personnel to search for the Medic Alert emblem in all emergencies and to take appropriate action. A general education program is directed at informing the public of the value of emergency medical identification.

For further information write Medic Alert, Box 1009, Turlock, CA 95380.

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[1] Hodge v. Paoli Memorial Hospital, et al., *433 F.Supp. 281 (E.D. Pa. 1977).*

[2] Citta v. Delaware Valley Hospital, *313 F.Supp. 301 (E.D. Pa. 1970).*

[3] *42 U.S.C. § 1983.*

[4] *See,* e.g., Doe v. Charleston Area Medical Center, Inc., *529 F.2d 638 (4th Cir. 1975);* Duffield v. Charleston Area Medical Center, Inc., *503 F.2d 512 (4th Cir. 1974);* Christhile v. Annapolis Emergency Hospital Association, Inc., *496 F.2d 1974 (4th Cir. 1974);* Sams v. Ohio Valley General Hospital Assn., *413 F.2d 826 (4th Cir. 1969);* Simkins v. Moses H. Cane Memorial Hospital, *323 F.2d 959 (4th Cir. 1963), cert. denied, 376 U.S. 938 (1964);* Citta v. Delaware Valley Hospital, supra.

[5] *See,* e.g. Schlein v. Milford Hospital, Inc., *561 F.2d 427 (2nd Cir. 1977);* Madry v. Sarel, *556 F.2d 303 (5th Cir. 1977);* Greco v. Orange Memorial Hospital Corp., *513 F. 2d 873 (5th Cir. 1975),* cert. denied, *423 U.S. 1000, 96 S.Ct. 433 (1976);* Jackson v. Norton-Children's Hospitals, Inc., *487 F.2d 502 (6th Cir. 1973),* cert. denied, *416 U.S. 1000, 94 S.Ct. 2413, 40 L.Ed.2d 776 (1974);* Doe v. Bellin Memorial Hospital, *479 F.2d 756 (7th Cir. 1973);* Briscoe v. Bock, *540 F.2d 392 (8th Cir. 1976);* Ascherman v. Presbyterian Hospital of Pacific Medical Center, Inc., *507 F.2d 1103 (9th Cir. 1974);* Ward v. St. Anthony Hospital, *476 F.2d 671 (10th Cir. 1973);* Holton v. Crozer-Chester Medical Center, *419 F.Supp. 334 (E.D.Pa. 1976);* Acosta v. Tyrone Hospital, *410 F.Supp. 1275 (W.D.Pa. 1974);* Ozlu v. Lock Haven Hospital, *369 F.Supp. 285 (M.D.Pa. 1974),* aff'd mem., *511 F.2d 1395 (3d Cir. 1975).*

[6] *42 U.S.C. §§ 291* et seq.

[7] Hodge v. Paoli Memorial Hospital, et al., supra *at 283-4.*

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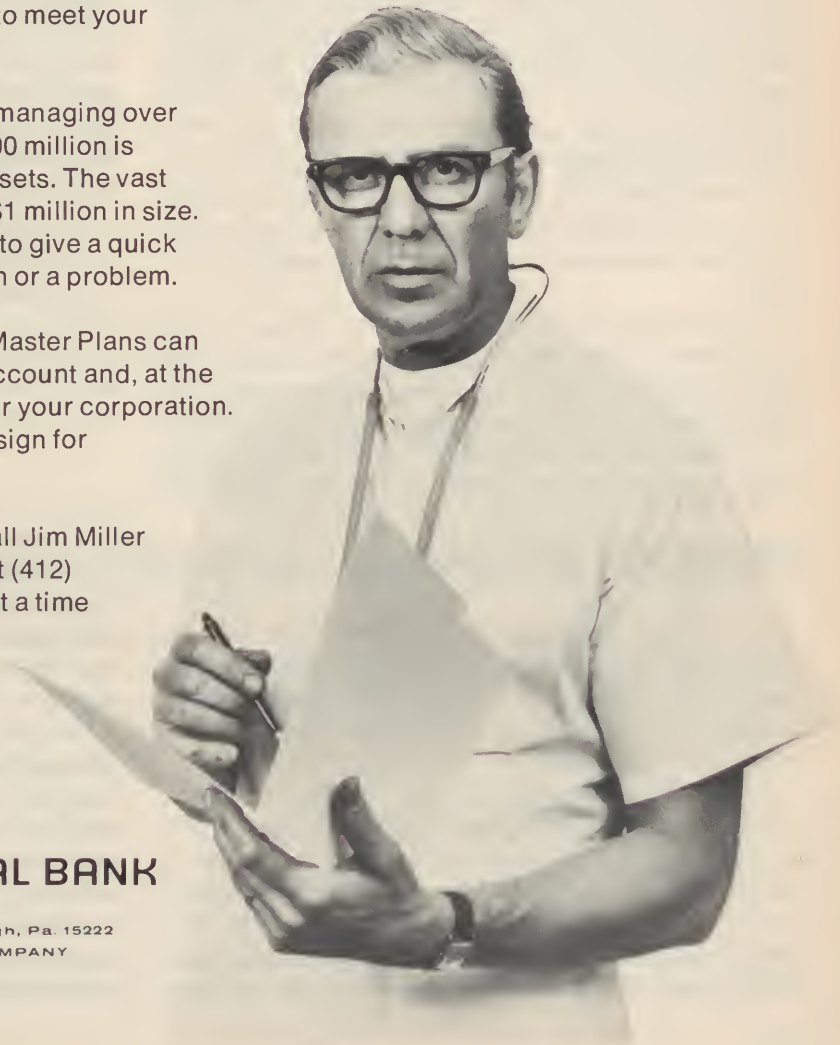
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editorials

A regulation question

Who regulates the regulators? This question, heard more now than ever before, is easier to ask than to answer. Possibly there is no answer. It may be that we, the American public, have created a monster that we are unable to control. It could be that legislation which we perceive as protection for the public has been abused by those who implement the law. And what recourse is there? Those who carry out the "legislative intent" are relatively immune from our protestations.

Several weeks ago, Jack Anderson's syndicated column, "Washington Merry-Go-Round," demanded, "Regulator Agencies Require Regulation." In this expose, charges of financial interest in businesses regulated by government agencies are leveled at officials of these same agencies. Specifically named were the Federal Communications Commission, the Environmental Protection Agency, and the Food and Drug Administration. It was noted that the former agencies, when officials were caught with their hands in the cookie jar, made an attempt to correct the problem by better internal control. Not so the FDA.

H.R. Haldeman points out in his new book, *The Ends of Power,* that the federal bureaucracy in Nixon's administration was, and still is, out of control. There are overlapping agencies, each pursuing and executing independent goals with virtually no controls.

What has gone wrong? Surely we did not intend that these things would happen. The founding fathers would be horrified at what has become of the government they dreamed about and fought for.

Bureaucrats are not elected and therefore have little or no public accountability. But they do wield a great deal of power because they are the implementers. John Rineman, in a speech before the Dauphin County Medical Society several years ago, discussed this problem, giving as an example the Clinical Laboratory Act of 1972. "The purpose of this act was to regulate only clinical laboratories. It was not the intent of the legislature to intrude into the private offices of physicians," he said. Yet this is exactly what happened. Why? Because a zealous bureaucratic government carried out its own interpretation of the intent of this law. The key words are *what it interpreted*—not what the sponsors of the act intended, not what the legislature which passed the act intended, but how the regulators interpreted the law. The only recourse seems to be through the courts, a time-consuming and expensive method of determining what a law really means.

Government would have us assume that these regulations and regulators are saving us money and improving our social well-being, whether in medicine or environment or any other of a number of areas. One physician aptly observed that the government spends more money advertising that it is saving the public's money than it actually saves. Nothing from the government is ever free or inexpensive. The regulators are not a small part of that expense.

Aside from the courts, we can exert some influence at the ballot box, even if indirectly. The candidate who recognizes the need for limitations on the unnecessary size of the bureaucracy and who exhibits true concern about steadily increasing bureaucratic excesses deserves our support. Perhaps this is the issue about which we should care most.

David A. Smith, M.D.
Medical Editor

'Patients are people' comment reappears

It is said that the health professions are only too often unmindful of the fact that patients are also people. The purpose of what follows is to review briefly only some of the aspects of this important health care problem.

In recent years diagnostic and therapeutic procedures have made enormous progress thanks largely to the contribution made by biomedical research, clinical investigation, and the educational programs instituted by agencies of organized medicine. Witness the many self-regulatory provisions which include mandatory post-graduate education, certification and re-certification as well as periodic auditing of professional standards in medical schools and hospitals.

Unfortunately, in spite of all this, there exists an undisputed crisis in the health care system. This is attested to by the public's concern with the cost of medical care (nursing, drugs, hospitals, and physicians) as well as with the attitude of health care personnel toward the patient. In all fairness, it must be pointed out that physicians' bills represent only a fraction of the sky-rocketing costs of an illness. Malpractice insurance, the need for the practice of "de-

fensive medicine," sophisticated laboratory procedures and hospital costs as well as medical research account for much of these bills.

Hospital management is now big business. Administrative problems are so complex that the patient is often relegated to secondary concern. Hospital personnel are often not trained to adopt a sympathetic attitude in an attempt to soften the impact of illness on a worried patient.

Norman Cousins, the distinguished editor of the *Saturday Review,* has recently reported ("Anatomy of an illness," *New England Journal of Medicine,* December 23, 1976. Vol. 195, No. 26, p. 1458) on his experience as a hospital patient. Speaking of many procedures he says, ". . . some of these tests seemed to me to be more an assertion of the clinical capability of the hospital than of concern for the well-being of the patient. I was astounded when four technicians from four different departments took four separate and substantial blood samples on the same day . . . the extensive and sometimes promiscuous use of x-ray equipment, the seemingly indiscriminate administration of tranquilizers and powerful painkillers, more for the convenience of hospital staff in managing patients than for therapeutic needs, and the regularity with which hospital routine takes precedence over the rest requirements of the patient (slumber, when it comes for an ill person, is an uncommon blessing and is not to be wantonly interrupted)—all of these and other practices seemed to me to be critical shortcomings of the modern hospital. I had a fast growing conviction that a hospital was no place for a person who was seriously ill."

Patient care in rural, less populated areas leaves much to be desired. The distribution of physicians, especially of medical specialists, in such districts is a problem of concern to public health authorities.

In the past, the public has been kept in ignorance of medical matters. This situation is fortunately changing for the better thanks to the cooperation of medical societies and the news media. However, individual patients and their families still complain that more often than not they are kept in the dark about the nature and progress of their illness. Physicians, they say, are too hurried, disinterested, and insensitive to the patient's psychosocial problems and his emotional reaction to the sickness.

Dr. Criep's comments first appeared in the January 14, 1978 issue of the Allegheny County Medical Society Bulletin. *The article was awarded first place in the* Bulletin's *1978 editorial contest.*

The remedy lies in the inclusion in the medical school curriculum and in the training of hospital interns and residents, the needs of a humanistic approach in dealing with the sick. Thus the future medical practitioner will come to realize that patients are people to be dealt with not only with scientific competence but also with compassion and understanding.

Leo H. Criep, M.D.
Pittsburgh

correspondence

Answers Dr. Greissinger

To the editor:

The questions raised by Dr. Walter M. Greissinger's letter in the March 1978 issue of PENNSYLVANIA MEDICINE were not completely answered by Dr. Masland's reply. It is important to set the record straight so Pennsylvania physicians will have the facts before making judgments.

The Department of Public Welfare did not "up its rates" for emergency room visits. The increase was enacted by the Legislature without the advice or consent of the department. The $12 emergency room visit fee goes to the hospital, not to the physicians.

Medicaid billing via computer will not be "very cumbersome" for physicians. It will require fewer strokes of a pen, or typewriter key, than the present system and will yield advantages that will become apparent as the system gets into place. PMS has had significant input into the process and numerous modifications have been made as a result of suggestions from PMS.

O. K. Stephenson, M.D., Medical Director
Office of Medical Programs
Pennsylvania Department of Public Welfare



Well, maybe there's nothing wrong with me right now, but can't you give me some preventive medicine?

Hypertension control program stresses detection

J. Edwin Wood, III, M.D.

As the Pennsylvania High Blood Pressure Control Program embarks on its statewide effort to detect and treat high blood pressure using the health resources of the Pennsylvania Department of Health, the American Heart Association, Pennsylvania Affiliate, and private physicians, it is important to share ideas about detection of high blood pressure, and response to the newly detected patient. This article outlines the current developmental state of those ideas.

Need for detection

The importance of detecting hypertension is made evident by several well documented facts:

1. Hypertension occurs in at least 20 percent of the adult population
2. Although the disease has virtually no symptoms at first, it eventually leads to high morbidity and mortality as a result of stroke, coronary disease, and renal and cardiac failure
3. Detection of the disorder is extraordinarily easy
4. Treatments for hypertension that are effective, inexpensive, and easily administered have been developed.

National, state, and local health education campaigns conducted in recent years have helped reduce the number of unknown hypertensives. In Pennsylvania, however, an estimated 600,000 adults are hypertensive and unaware of it. An additional 500,000 are aware but continue to do nothing about their condition. Thus the challenge is formidable.

It is, therefore, of the greatest importance that all who are or will be participating in this developing program recognize that detection of hypertension is only the first step. Access to medical care and continuing medical management must be arranged in advance, for the patient may be harmed rather than helped by the negative reaction created.

This article is the second in a series on hypertension and the control program of the Pennsylvania Department of Health and the American Heart Association, Pennsylvania Affiliate. Dr. Wood, vice chairman of the Advisory Council for the Pennsylvania High Blood Pressure Control Program, is director of the department of medicine at Pennsylvania Hospital and chairman of the High Blood Pressure Task Force of the American Heart Association, Pennsylvania Affiliate.



MAY
High Blood Pressure Month

Organizing for detection

Detection cannot be limited to physicians and their staffs. In the initial or primary screening, large scale participation is needed by interested agencies and groups, such as the Heart Association, Red Cross, VNAs, and professional groups (pharmacists, optometrists, dentists, nurses, etc.).

When a person's pressure appears elevated, he will be referred for confirmation to a secondary source, most frequently a state or county health center. Following a careful review of a series of Risk Factor tests conducted by the state health center, the patient will be referred to a physician for diagnosis and treatment, asked to return for a recheck, or advised to return for a periodic, usually annual, review.

Key to reliable detection

Two aspects of the Pennsylvania High Blood Pressure Control Program assure the program's soundness: 1) the training program in blood pressure measurement, and 2) the procedures for confirmation.

Accurate blood pressure measurement offers the key to the determination of hypertension. To develop this precision, a statewide training program in blood pressure observation has been underway for nearly a year. The procedure assures accuracy to within two mm Hg per reading. The length of the course varies according to a person's background and experience; it includes testing and periodic reevaluation. Precision and reliability are critical in a detection program of this magnitude.

Confirmation of high blood pressure follows the criteria outlined in the Moser Report[1]:

1. Blood pressure measurements should be taken on at least *two* separate occasions unless on the first visit the diastolic pressure averages greater than 120 mm Hg, in which case immediate referral for medical evaluation and treatment is advised.
2. At each visit, the blood pressure should be measured two or more times and the average recorded (diastolic recorded at the disappearance of sound[2])
3. If initial reading averages 160/95 mm Hg or above for either or both systolic and diastolic, the level should be confirmed within a month
4. If initial reading averages 140/90 mm Hg to 160/95 mm Hg: under age 50, recheck within 2-3 months; age 50 and over, recheck within 6-9 months

If the initial reading is outside the aforementioned limits and the first recheck agrees, referral will be made for medical evaluation and treatment. If the first recheck is within those limits, at least one more recheck is necessary before a decision regarding referral is made. All initial or recheck pressures averaging below 140/90 mm Hg should be rechecked annually.

Excessive arterial blood pressure is a common disorder which carries great risk to the individual. This disorder is easily detected and easily treated. We of the health care professions have a responsibility to work together, through this program, to detect and control high blood pressure. □

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the management consultant's advisory

LEIF C. BECK, PUBLISHER

This sample issue is a reprint of an actual issue received by more than 500 subscribing physicians and medical office personnel. For subscription details, please see the card attached in the magazine.

ISSUE 78-3

A monthly digest of observations and recommendations arising from the editors' ongoing full-time work as advisors to medical practices on such matters as business systems, personnel management, office facilities, group practice problems, professional corporations, retirement planning and personal finances. The "Action Note" at the end of each item provides the reader with a reminder for prompt action and handy future reference.

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rsonnel

1 HOW TO GIVE AN EMPLOYEE A PAY RAISE

our surveys of medical practices, we ten ask the assistants how their last pay se was handled. Replies range from lmorous to alarming, with surprisingly v good stories. We are thus firmly con-nced that most doctors fail miserably at ectively motivating their employees rough salary increases.

A pay raise should be the culmination a sincere effort to evaluate each indi-vidual's work performance. Having done t, the doctor(s) and/or manager should et privately with the employee to ac-tually discuss her good and bad features. I she has performed well she should be t d so, to avoid the common complaint: 'o one has ever told me I'm doing a good job." Deficiencies in her work should, of course, similarly be discussed.

With this discussion background, the pay raise (whether large or small) would become an obvious function of an employee's contribution to the practice's success. The personal and confidential description of the employer's decision likewise indicates that the assistant is respected enough as an individual to be given such time and attention. In effect, the pay raise serves its important function—to reward employees for their work and motivate them to continue striving for improvement.

Practices which simply grant across-the-board increases based upon cost of living changes (an approach which we abhor) should nevertheless follow our suggested routine. Even such a raise recognizes that the employee has performed well enough to deserve routine adjustment, and she deserves the courtesy of being told so.

Effective discussion of an assistant's job performance can usually best be accomplished in the pay raise setting. Doctors or managers who fear that this setting will invite complaints for still higher pay are, in our view, not handling the compensation situation adequately anyway.

ACTION NOTE—Be sure pay raises are considered as motivational tools; grant them only upon conscientious evaluation of and personal discussion with each employee involved.

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Financial Management

2 SEEK YOUR ACCOUNTANT'S ADVICE ON INTERNAL AUDIT CONTROLS

Why do so many medical practices totally lack basic control systems intended to prevent embezzlement? The answer may partially be in physicians' lack of training in business systems, but that is why they should expect help from people who are so trained—their accountants.

Unfortunately, we encounter accountants who fail to offer this advice to their medical clients. Still worse, some of them apparently avoid providing the help out of concern that they might thereafter become liable if a theft should nevertheless occur. Some accountants have falsely suggested that creating the controls is only a function of full-scale, "certified" audits, which small medical practices do not require.

We recommend that physicians and their office managers request reports from their accountants, **in writing,** evaluating the systems from the standpoint of audit controls. The reports should then recommend reasonable safeguards which will probably prevent or discourage theft. They might, for instance, consider such subjects as:

1. Opening the mail and recording checks received;
2. Handling of cash payments at the reception desk;
3. Posting to and totalling of each day's transaction sheets;
4. Managing the petty cash box; and
5. Writing and signing the practice's checks, including payroll.

The accountant should be assured that his advice will not be taken as a guarantee against loss, and he may well say so in his report. That should be satisfactory to the medical practice client which requires his **advice,** not his guarantee. We believe that any accountant unwilling to so involve himself as an advisor to his client on a fee-paying basis should be replaced.

ACTION NOTE—Ask your accountant for written instructions on safeguards against embezzlement for your office's business systems; insist on such help or else change accountants.

Collections

3 OBTAIN THE PATIENT'S CLAIM NUMBER IN NO-FAULT INSURED CASES

No-fault auto insurance presents physicians with some real advantages. Primarily, it virtually assures prompt payment of medical bills avoiding the so-called "litigation cases" so swelling orthopedic surgeons' accounts receivable, for instance. The insurance also provides an alternative to Blue Shield or Medicare payment in many (though not all) instances so profile restrictions on fees might be avoided.*

Many states' no-fault auto insurance laws require those insurers to honor claims within short time spans, often 30 days, at the risk of fairly costly penalties. As a result, medical offices have become puzzled at the much longer delays they sometimes encounter. We believe an explanation might help those offices avoid the delays in the future.

A no-fault insurer usually becomes subject to the payment obligation only when it has actually received a "claim". Thus, the patient must have reported the accident to his or her insurance company, upon which a claim file would be opened. The file would receive a "claim number", which seems to be the essential reference.

When obtaining basic information from a no-fault patient, the medical assistant should be certain to ask if the accident has been reported to the insurance company and whether a claim number has been provided. If the patient has not reported the accident or did not obtain the claim number, he or she should be encouraged to do so and pass on that number. Some offices even help patients make the claim by telephone so the number can be obtained.

A physician's bill to the insurer should contain that claim number as the "ticket" for prompt handling. If it is not then paid within the law's time limit, the described penalty should be demanded.

*Some no-fault coverages provide for an offset against Blue Shield and/or Medicare coverage, in which case those primary health insurers must be billed first.

ACTION NOTE—To help assure prompt payment of your no-fault insured services, be sure to seek out the patient's "claim number"; instruct your staff to advise or assist the patient in obtaining that number.

Office Facilities

4 BEWARE OF "CONDITIONING" IN OFFICE BUILDING CONSTRUCTION

Investing in the construction and ownership of one's own medical building is a once-in-a-lifetime event for some successful physicians. Likewise, the association of several doctors to develop a larger multi-practice building is another exciting one-time step. Such incursions by medical doctors into construction are, however, inexperienced ventures into a tough business.

We are often puzzled at doctors' descriptions of construction costs seemingly far below normal ranges. To us, the basic figure for medical buildings (which are more expensive than most other types of office buildings) these days is about $50 per square foot. If far lower quotes are given we urge very skeptical evaluation.

Many builders tend to understate their cost estimates and then increase them as the design and development stages progress. This is known as "conditioning", for as a customer continues his interest he may become too far committed to effectively object. By the time the formal construction contract is ready to be signed, the price might be far above the original quote.

As a physician begins considering a potential builder, he should be conscious of the conditioning possibility. One important attempt at protection would be to inquire of the contractor's last three or four completed customers what percentage increase developed from the original figures. Conservatism would justify applying the same "mark-up" to the present quotation. At any rate, being carefully alert to the conditioning possibility should in itself help the doctor's or group's self-protection.

ACTION NOTE—Be aware that many builders tend to "condition" their potential customers into signing more costly construction contracts; check your potential builder's record in this regard by direct calls to former customers.

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Scheduling

5 COLOR CODE YOUR APPOINTMENT BOOK

In so many aspects of office practice, the use of colors for identification can be extremely helpful. Charts should be color coded by patient name (or number) and by year of last activity; internal records and financial forms can be variously colored for quick reference; and so on.

This color coding concept is invaluable at the reception desk. Various time slots in an office appointment book can be shaded various colors to guide the receptionist as to scheduling priorities. In an OB-GYN practice, for example, a doctor wishing to see only OB check-ups from 11:00 to 12:00 could have that hour's space shaded light red. The hour from 1:00 to 2:00 might be reserved for new GYN patients, and it could be shaded in light blue. An internist might wish to reserve his first two hours for complete physicals, shaded light green; while a family practice office might shade a late afternoon's hour to indicate that it is reserved for "work-ins".

The color coding concept is helpful since the pressure of many phone calls and in-office patients may too easily cause even an excellent receptionist to overlook scheduling principles without the visual aid. Furthermore, when other assistants are filling in at the desk because of illness, vacations, lunch breaks and the like, the visual aid is particularly valuable to the less experienced substitute. We find, by the way, that a receptionist is away from her desk at least 30% of the time for such reasons. More scheduling errors occur during those absences unless colors are used.

The shadings could be preprinted right into the appointment book when the sheets are originally printed. However, it is both cheaper and easier for an office assistant to shade the various time slots with colored pencils, preparing a supply of pages well into the future. Several months of pages can easily be prepared in a slack half hour.

ACTION NOTE—Assure that your decisions as to scheduling priorities are actually followed by having your appointment book time slots color coded.

Group Practice

6 HOW LONG SHOULD A GROUP SUPPORT A DISABLED PARTNER?

Whether partnership or professional corporation, a group of physicians practicing together must be extremely critical of its inter-doctor arrangements. We particularly notice a lack of care in many groups' provisions for continued income upon a partner's (or co-shareholder's) absence due to sickness or injury.

Perhaps the desire to support a disabled partner overwhelms common sense, for group arrangements too often provide "sick pay" longer than the healthy doctors can afford. The result, however, can be a double burden on the healthy doctors: covering the practice without the disabled member's work while being squeezed on income in order to pay his full salary. This combination has in several known cases been extremely divisive to otherwise very compatible groups.

Recognizing the problems, we recommend the following priorities as to a partner's illness or injury. First, his income should continue for the few months during which accounts receivable will easily carry him and his partners. Second, however, the continuing healthy partners must be assured that their own incomes will not be diminished in order to support the disabled doctor further. After all, they are continuing to work and should not bear the brunt of another's misfortune—especially since each person can plan for his own protection through personal finances and disability insurance. Third and last, if income is expected to be available even after the healthy partners have been regularly paid, there may be additional sick pay to satisfy the group's desire to support each other.

This set of priorities should be kept strongly in mind when the physicians determine or re-evaluate their sick pay provisions. A family practice group, for example, might find that even three months' full sick pay will be oppressive. A surgical group may be able to provide three or more months' full pay and some additional months' fractional pay. But the likely financial effects of a member's prolonged absence simply must be faced It is too often casually overlooked.

ACTION NOTE—Be sure your partnership or corporate agreement will not impose a hardship on the continuing, healthy doctors in case of one's illness or injury; consider the protection of the continuing doctors' incomes as a higher priority than providing sick pay.

Collections

7 " RED FOLDER" DELINQUENT ACCOUNTS AS A COLLECTION FOLLOW-UP

Primary care practices have one particular economic advantage over other specialties—most of their patients will return often enough to be personally confronted as to delinquent accounts. The advantage often results in higher collection ratios and lower accounts receivable than, say, surgical practices.

Despite this advantage, primary care offices must still be diligent in identifying delinquent patients. Furthermore, the office assistants must effectively convince these patients to pay their bills. The alternative of simply threatening to drop delinquent patients from one's practice is unfortunate.

About a year ago, we visited a pediatric group with a unique but effective approach towards delinquent accounts. It informed its patients and parents that if an account should become overdue (outstanding for 60 days), the patient's medical chart would be "red foldered". The chart would simply be placed within a red file jacket, after which all visits would have to be "cash only" until the red jacket can be removed.

When a red foldered patient should return for his or her next office visit, the receptionist or other assistant would show the red file jacket to the parent and indicate a need to discuss the account. Patients and parents thus had a visual "pressure" to make payments or arrangements in order to have the red folders removed. The staff, meanwhile, had a handy means of identifying the delinquent patients and a visual aid (a "crutch") for requesting payment.

ACTION NOTE—If your practice has many returning patients, as do primary care specialties, consider "red foldering" delinquent patients' charts as a collection follow-up device.

Personnel

8 THE WAGE AND HOUR LAWS ON OVERTIME PAY ARE BECOMING SERIOUS

Medical offices have a notorious reputation for expecting employees to work beyond their usual quitting times. The reason is partly the shared obligation to serve patients in medical need, even if

their visits should stretch office hours several hours late. In effect, the professional attitude of the physicians influences the staff to similarly disregard usual working hours.

There are both Federal and state laws limiting the number of hours a person may work without receiving overtime pay. Despite these Wage and Hour Laws, however, we find very few offices that actually provide overtime pay even in obvious situations. The laws are becoming more actively enforced to the extent that a variety of physicians' offices throughout the U.S. have actually been subject to "wage and hour audits". The results of those audits have been costly enough that all our readers should take heed.

The basic overtime pay rule is simple to state: an employee must be paid time-and-a-half for over 40 hours worked in a week. A promise of "compensatory time off" is ineffective, and even time off actually given in a later week will not count. While lunch hours need not be counted, an employee working on her lunch hour (even if she munches her sandwich while working) must be credited with that time as work-time. Similarly, an employee coming in early or staying late must be credited with the extra hours even if she was not required or asked to do the extra work.

Very few medical employees are exempt from the wage and hour laws. An office manager would be exempt **only** if over 80% of her time is spent in "managing" – she is not exempt if she spends much of her time doing the bookkeeping, manning the reception desk, etc. Even a registered nurse qualifies for overtime pay unless the bulk of her work can be performed **only** by a registered nurse – which is not usually the case in physicians' offices.

While examples could continue, our readers should simply assume that their offices are subject to the wage and hour laws. Furthermore, the fact of increased Labor Department surveillance means that these rules should be carefully obeyed as part of good business practice.

ACTION NOTE – Recognize the seriousness of the Wage and Hour Laws, including the increasing number of audits upon medical offices; establish a clear policy of paying overtime for your employees' actual hours over 40 in any week.

Supply Systems

9 WHEN SHOULD A SUPPLY ITEM BE REORDERED?

How often has your office been without a vaccine required for a patient awaiting your injection? Have you experienced the annoyance of having run out of a certain type bandage when a patient needs it promptly? Running out of a supply item is an avoidable frustration, providing the responsible assistant (whom we call "the central supply person"*) has specific guidelines to follow.

The guidelines require keeping a record of each supply item and its normal rate of use. Also required is the usual amount of time elapsed from ordering an item and actually receiving it. These pieces of information will vary dramatically from item to item, as one lab supply may have heavy demand while a certain vaccine may have a long average delivery time.

We recommend establishing a specific "minimum quantity" to be on hand for each item, at which point it must be reordered. Our rough rule of thumb calls for reordering no later than when the supply is down to **twice** what is usually needed to carry the practice through the usual reorder/delivery period. Some items, such as flu vaccines for example, should have a considerably higher minimum quantity to be prepared for possible heavy "runs", but there should be a specifically known figure for every product in the office.

A supply's "minimum quantity" should be determined and written on a record card for handy and continuing reference. The figure might be changed as experience dictates, but having a known point at which to reorder can help reduce or eliminate annoying supply failures.

*See "Assigning Central Responsibility Helps Give Greater Supply Control", Issue #78-1, item 9.

ACTION NOTE—To avoid running out of any supply item, be sure your central supply person identifies and records the "minimum quantity" of each item to be on hand before it must be reordered.

Professional Corporations

10 DO YOUR EXPENSE PAYMENTS ACTUALLY CONFORM TO YOUR EMPLOYMENT AGREEMENT?

Many incorporated physicians' employment agreements seem to be long-forgotten pieces of "window-dressing". They were presented by the incorporating attorney at an organizational meeting, signed by the doctors involved and then filed away without later reference. For several reasons, disregarding this corporate document can be very unfortunate.

One of the reasons is becoming particularly costly tax-wise. We know of IRS agents who have specifically asked for and reviewed corporate documents when auditing the personal tax returns of incorporated physicians. These agents have been especially interested in the provisions regarding payment of business expenses such as automobile costs, professional meetings and educational payments, entertainment expenses and club dues, etc.

Many employment agreements simply state that all business expenses shall be paid by the corporation as employer; others will specify which expenses are to be paid by the corporation and which are to be borne personally. Any expenses contractually assumed by the corporation would thus not be personally deductible by a physician who pays them out of his pocket. The IRS agents have been so claiming on the correct premise that the expenses were not the doctor's obligation at all.

In some cases, the opposite situation has presented itself. An employment contract might impose certain expenses upon the physician(s), but for convenience the corporation has paid them. Here, the expenses are not deductible by the corporation, being rather "preferential dividends" as payment of its shareholder-physician's obligations.

In either direction, the disallowance of business expense deductions for failure to follow employment contract provisions is unfortunate. The situation is totally avoidable simply by a doctor's reference to his document. If it does not recite the actual arrangements, the contract can easily be changed to conform to the facts.

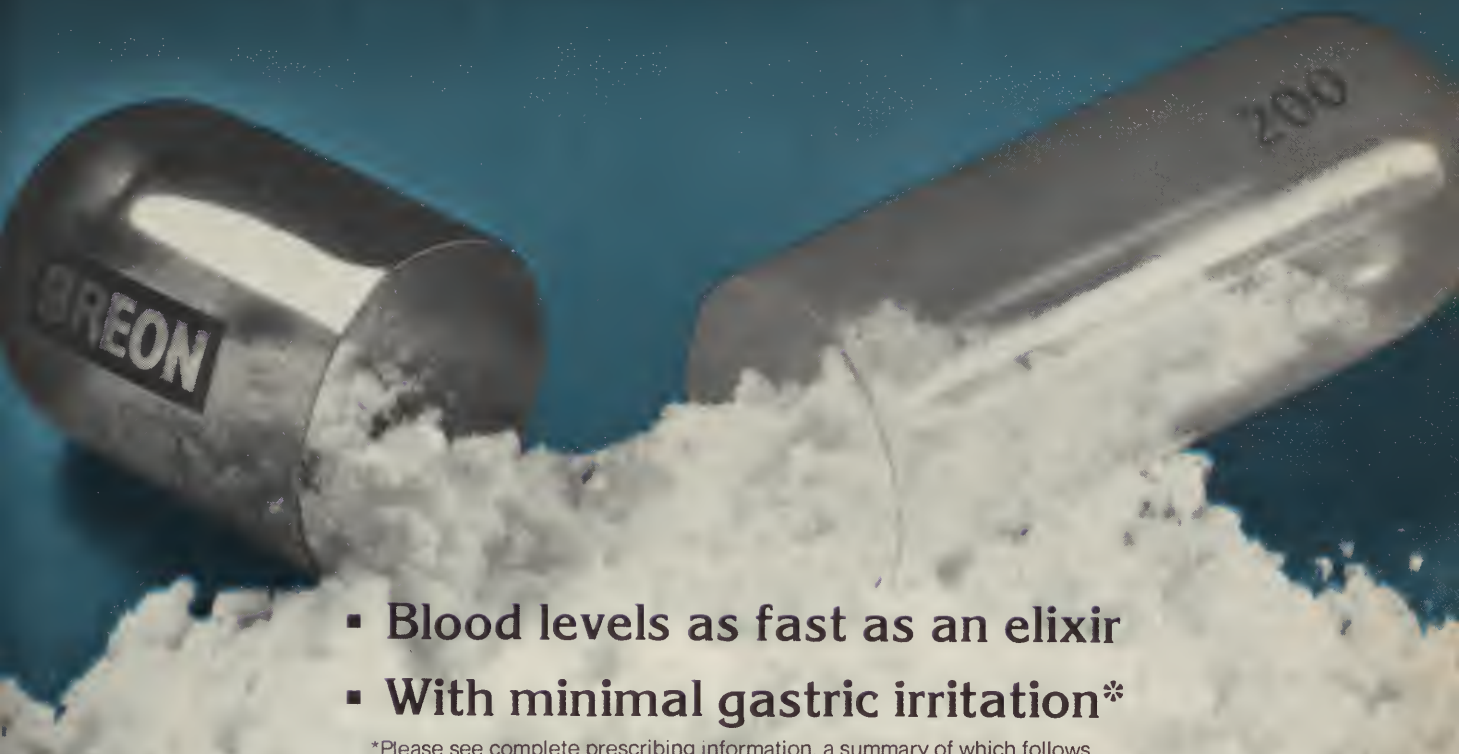
ACTION NOTE—Be sure your employment agreement imposes responsibility for paying business expenses as they actually are being paid; avoid IRS attack based upon the divergence of document provisions from actual fact.

A Difference in Theophylline Therapy

micro-pulverized

BRONKODYL® Capsules

brand of theophylline, USP anhydrous



- Blood levels as fast as an elixir
- With minimal gastric irritation*

*Please see complete prescribing information, a summary of which follows.

DESCRIPTION:
Each green and white hard gelatin capsule contains theophylline USP anhydrous, 200 mg., in a micro-pulverized form. Each brown and white hard gelatin capsule contains 100 mg. The elixir contains 80 mg. theophylline per 15 ml. in a 20% alcohol elixir (approximately 20 calories, 0.9 gm carbohydrate per tablespoonful).

ACTION: Theophylline is a methylxanthine which relaxes the smooth musculature of the bronchioles through its inhibition of the conversion of cyclic adenosine monophosphate to adenosine monophosphate by phosphodiesterase. It also has diuretic, cardiotonic, and CNS stimulant effects.

INDICATIONS: Bronkodyl is indicated for symptomatic relaxation of bronchiolar spasm in the chronic obstructive bronchopulmonary diseases; e.g., bronchial asthma, chronic bronchitis and pulmonary emphysema.

CONTRAINDICATIONS: Bronkodyl is contraindicated in persons known to have had serious idiosyncratic responses to theophylline, its salts, or the other methylxanthines, theobromine, or caffeine and may be contraindicated in peptic ulcer.

WARNINGS: All methylxanthines should be used with caution in children and in others who are currently taking bronchodilator products, especially in rectal dosage form, which may contain theophylline or related drugs.

USAGE IN PREGNANCY: Although theophylline has been used for many years, with no evidence of adverse fetal effect or teratogenicity, its safety in pregnancy has not been established. Therefore use of Bronkodyl during lactation or in women of childbearing potential requires that possible benefits of the drug be weighed against possible hazards to fetus or child.

PRECAUTIONS: Bronkodyl should be used with caution in patients with cardiac or circulatory disease.

ADVERSE REACTIONS: Gastrointestinal: Epigastric distress, nausea, vomiting. Cardiovascular: palpitations. CNS: Insomnia, restlessness, irritability, convulsion.

DOSAGE AND ADMINISTRATION: Adults: Usual dosage of Bronkodyl is 200 mg. every 6 hours (four doses in each 24 hours). This dosage may be adjusted to reflect individual clinical response as an indication of slow or rapid metabolism of the drug. If adverse reactions are encountered, each dose may be reduced, or the interval between doses may be lengthened, or both. If clinical response is not satisfactory, indicating possible rapid inactivation of the drug, dosage may be gradually increased to achieve the desired response. In some instances of either too slow or too rapid metabolism, plasma levels of theophylline should be determined and dosage adjusted accordingly to achieve levels above 10 mcg/ml, but not to exceed 20 mcg/ml.

Dosage in Children: Usual dosage should be based on administration of 10 mg per kg per 24 hours, divided in 4 doses per day, given every 6 hours. As this may not be possible with use of the capsules, Bronkodyl elixir may be used. Theophylline saliva levels (approximately 60% of simultaneous blood levels), may facilitate dosage adjustments, especially in children, to obtain appropriate response.

HOW SUPPLIED:
Bronkodyl 100 mg., brown and white capsules in 100's, Code #1831.
Bronkodyl 200 mg., green and white capsules in 100's, Code #1833.
Bronkodyl Elixir, 80 mg. per 15 ml, in pints, Code #1835.

BREON LABORATORIES INC.
90 Park Avenue, New York, N.Y. 10016

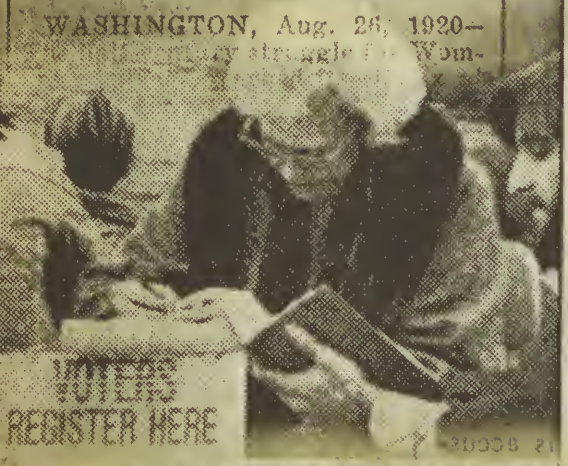
COLBY PROCLAIMS WOMAN SUFFRAGE

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MILITANTS VEXED AT PRIVACY.

Wanted Movies of Ceremony, But Both Factions Are

WASHINGTON, Aug. 26, 1920—



Social Security Bill Is Signed; Gives Pensions to Aged, Job

Roosevelt Approves Message Intended to Benefit 30,0 Persons When States Adopt Cooperating Laws–He the Measure 'Cornerstone' of His Economic Progr

WASHINGTON, Aug. 1 The Social Security Bill, p a broad program of unemp insurance and old age and counted upon to ben 20,000,000 persons, becam day when it was signed b dent Roosevelt in the pre those chiefly responsible ting it through C s.

Mr. Roosevelt cal "the cornerstone wh is being m s comple ri to

SENATE APPROVES 18-YEAR OLD VOTE IN ALL ELECTIONS

Amendment to Constitution is Sent to House, Where Passage is Expected

WASHINGTON, March 10, 1971—The Senate approved today 94 to 0 and sen to

TRUMAN CLOSES ITED NATIONS CONFEREN WITH PLEA TO TRANSLATE CHARTER INTO DEEDS

NEW WORLD HOPE

President Hails 'Great Instrument of Peace,' Insists It Be Used

HISTORIC LANDMARK

Meeting Gives Standing Ovation as Executive Pictures Peace Gain

"If we fail to use it," he declared to the solemn final meeting of the delegates, 'we shall betray all of those who have died in order that we might meet here in freedom and safety to create it.'

"If we seek to use it selfishly—for the advantage of any one nation or any small group of nations—we shall be equally guilty of that betrayal."

Fervent Interpolation

The President, speaking in the auditorium of the War Memorial Opera House, built in memory of sons of the Golden Gate city who gave their lives in the first World War, in which he himself served, seemed to give unconscious expression to the solemn feeling of the occasion when, at the outset of his speech, he interpolated the words, half a hope, half a prayer:

"Oh, what a great day this can be in history!"

Just before the plenary session

SIGNED the Draft Ends No

WASHINGTON, Jan. 27, 1973—"With the signing of the peace agreement in Paris today, and after receiving a report from the



PATIENT PACKAGE INSERTS: A CONCEPT WHOSE TIME HAS COME?

The consumer's right to know is an irreversible and desirable trend of the Seventies. It extends, and properly, to a patient's right to know more about his or her prescription medications. One way, gaining favor, is through patient package inserts. Wisely-prepared and properly distributed when medically indicated, they could markedly improve patient knowledge and drug therapy—laudable goals by anyone's standards.

The PMA endorses these goals and will work with government, the health professions and consumers to achieve them.

The Advantages

The concept holds promise of benefits: better patient understanding of the product prescribed, better adherence to the treatment plan, and more awareness of possible side reactions.

Every doctor has had patients who fail to finish antibiotic regimens because they feel better. Some patients assume that if one tranquilizer or analgesic is good, two may be twice as good. Still others fail to report dizziness while on antihypertensive therapy —and so on.

Problems like these might arise less often if the patient received written information in addition to verbal instructions. Some studies suggest that patients are more receptive to such materials, and they more often understand the verbal instructions and follow them, when inserts are used.

The Disadvantages

There are also some potential problems. Obviously, the inserts must be clearly phrased, without extraneous or complex detail. How much information is enough? How can it be kept current? Should all patients receive the same information? Should inserts be included with all drugs? Should only potential problems be listed or are patients better off with a "fair balance" presentation that describes usefulness as well as drawbacks?

These and similar questions require answers, since model inserts have yet to be properly developed and tested. Despite the need for these studies, the FDA is proceeding prematurely with inserts on selected products. We think the Congress is the only place where the matter can be given the proper legal status and direction, particularly since it represents a conceptual change in the legal, medical and social framework of the nation's prescription drug information system.

The Solution

The PMA believes that carefully-devised pilot studies of various kinds of inserts are needed. They should be developed and implemented with full participation by doctors, pharmacists, consumers, communications experts and the drug industry. Such studies will provide reliable pathways to follow, so that inserts will be useful aids to medical practice.

And particularly we think that you should be closely involved in this debate and in these studies and decisions. Otherwise, people with less experience and qualifications may control the purposes, content and use of a tool with considerable promise for improved patient care. It could make a difference in your practice tomorrow, and more importantly, in the health of your patients.

PMA
THE PHARMACEUTICAL MANUFACTURERS ASSOCIATION
1155 FIFTEENTH ST., N. W., WASHINGTON, D. C. 20005

Clinical experience & continuing confidence

KAON® ELIXIR was introduced in **1954,** followed by KAON® TABLETS in **1963.** Decades of clinical experience indicate acceptability, effectiveness, and safety in the majority of patients; should abdominal pain occur, therapy should be discontinued. Both have been taken by patient after patient, day after day, year after year, to correct potassium deficiencies. Both have consistently demonstrated their value when diet alone is inadequate for potassium replacement.

Kaon® Elixir
(potassium gluconate)

Kaon® Tabs
(potassium gluconate)

BRIEF SUMMARY
Kaon Tablets/Kaon Elixir

KAON® (potassium gluconate) TABLETS

Description: Each sugar-coated tablet supplies 5 mEq. of elemental potassium (as potassium gluconate 1.17 Gm.). Kaon Tablets are sugar coated, not enteric coated, which favors dissolution in the stomach and absorption before reaching the small intestine where the lesions with enteric potassium chloride have occurred. The sugar coating merely adds to palatability and ease of swallowing, not to delay absorption as does the enteric coating.
Indications: Oral potassium therapy for the prevention and treatment of hypokalemia which may occur secondary to diuretic or corticosteroid administration. It may be used in the treatment of cardiac arrhythmias due to digitalis intoxication.
Contraindications: Severe renal impairment with oliguria or azotemia, untreated Addison's disease, adynamia episodica hereditaria, acute dehydration, heat cramps and hyperkalemia from any cause.
Warning: There have been several reports, published and unpublished, concerning nonspecific small-bowel lesions consisting of stenosis, with or without ulceration, associated with the administration of enteric-coated potassium tablets alone or when they are used with nonenteric-coated thiazides or certain other oral diuretics. These small-bowel lesions have caused obstruction, hemorrhage and perforation. Surgery was frequently required and deaths have occurred. Available information tends to implicate enteric-coated potassium salts, although lesions of this type also occur spontaneously. Therefore, coated potassium-containing formulations should be administered only when indicated and should be discontinued immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur. Coated potassium tablets should be used only when adequate dietary supplementation is not practical.
Precautions: In response to a rise in the concentration of body potassium, renal excretion of the ion is increased. With normal kidney function, it is difficult, therefore, to produce potassium intoxication by oral administration. However, potassium supplements must be administered with caution, since the amount of the deficiency or daily dosage is not accurately known. Frequent checks of the clinical status of the patient, and periodic ECG and/or serum potassium levels should be made. High serum concentra-

1954
1978

Time is the test of all things



tions of potassium ion may cause death through cardiac depression, arrhythmias or arrest. This drug should be used with caution in the presence of cardiac disease.

In hypokalemic states, especially in patients on a salt-free diet, hypochloremic alkalosis is a possibility that may require chloride as well as potassium supplementation. In these circumstances, Kaon (potassium gluconate) should be supplemented with chloride. Ammonium chloride is an excellent source of chloride ion (18.7 mEq. per Gram), but it should not be used in patients with hepatic cirrhosis where ammonium salts are contraindicated. Other sources for chloride are sodium chloride and Diluted Hydrochloric Acid, U.S.P.

It should also be kept in mind that ammonium cycle cation exchange resin, sometimes used to treat hyperkalemia, should not be administered to patients with hepatic cirrhosis.

Adverse Reactions: Nausea, vomiting, diarrhea and abdominal discomfort have been reported. The symptoms and signs of potassium intoxication include paresthesias of the extremities, flaccid paralysis, listlessness, mental confusion, weakness and heaviness of the legs, fall in blood pressure, cardiac arrhythmias and heart block. Hyperkalemia may exhibit the following electrocardiographic abnormalities: disappearance of the P wave, widening and slurring of QRS complex, changes of the S-T segment, tall peaked T waves, etc.

Overdosage: Potassium intoxication may result from overdosage of potassium or from therapeutic dosage in conditions stated under "Contraindications." Hyperkalemia, when detected, must be treated immediately because lethal levels can be reached in a few hours.

KAON® (potassium gluconate) ELIXIR

Description: Each 15 ml. (tablespoonful) supplies 20 mEq. of elemental potassium (as potassium gluconate, 4.68 Gm.) with saccharin and aromatics. Alcohol 5%.

Indications: See Kaon Tablets.

Precautions: See Kaon Tablets.

In hypochloremic alkalosis, potassium replacement with potassium chloride (e.g., Kaochlor® 10% Liquid) may be more advantageous than with other potassium salts.

Adverse Reactions: See Kaon Tablets.

Overdosage: See Kaon Tablets.

WARREN-TEED
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DIVISION OF **ADRIA LABORATORIES INC.**
COLUMBUS, OHIO 43215



Special Report—
A comprehensive plan for spinal cord injury services in Pennsylvania

Foreword

Spinal cord damage resulting in paralysis constitutes one of the most devastating illnesses known to man. The instantaneous effect of such damage can result in total disruption of the victim's life and can often subject him to permanent suffering and institutionalization. His brain, his heart, his potential may be entrapped forever.

The majority of spinal cord damage occurs in males under the age of 25. Their productive capacity is an immeasurable but needless loss to society.

As a result of advances made in the past twenty years in medicine, surgery, and supporting mechanisms, these victims can now be expected to survive a normal lifespan. Our society can provide paraplegics and quadriplegics (those paralyzed from the neck down) with an alternative to lifelong imprisonment.

The potential exists. Yet, too often, medical expertise and continuing care are haphazard and fragmented; they fail to achieve their goal.

Ever-increasing numbers of spinal cord injured people present social and medical challenges. We must channel existing skills into a system that will provide a smooth and steady progression through a complete care program. Rehabilitation measures and vocational training are absolute necessities. The astronomical monies involved in maintaining helpless victims must be transferred to providing the care that will return them to fulfilling and productive lives.

Therefore, on February 11, 1976, I announced the appointment of a Spinal Cord Injury Committee to formulate a plan for a statewide program for the management of spinal cord injuries.

The Committee was composed of a variety of individuals with distinguished backgrounds in neurosurgery, rehabilitative medicine, occupational therapy, and program planning related specifically to problems of spinal cord injured persons. Among these individuals are two persons who have suffered spinal cord injuries. (The following page identifies participating Committee members.)

The Committee had a number of meetings during the ensuing 18 months including the conducting of a survey covering 265 hospitals in the State. The Committee then formed four subcommittees to prepare recommendations in the areas of (1) Patient Retrieval (transportation of patients), (2) Rehabilitation and Chronic Care, (3) Statistical Information and Geographic Locations, and (4) Acute Care, which are included in the following report.

I wish to commend the Committee for its dedication in developing this report and the fine manner in which they have carried out their original charge.

Leonard Bachman, M.D.
Secretary of Health

Spinal Cord Injury Committee

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Community Medical Center
Scranton, Pennsylvania 18503

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Edward Zerdy, Statistician
Pennsylvania Department of Health

Introduction

The Spinal Cord Injury Committee was developed through the Health Advisory Council of the State of Pennsylvania and was supervised in its study by Secretary of Health Leonard Bachman, M.D.

Pennsylvania's need for a study of spinal cord injuries is obvious. Note the enormous loss of human resources in these paralyzed individuals; the tragedy affecting their families and communities; the astronomical medical expenses involved in the average lifetimes; and the loss of individual productivity, estimated to be nearly $1.2 million of the gross national product per case. Recent developments in the treatment of spinal cord injury impel us to question the care these patients receive in our Commonwealth.

Through frequent sessions the Committee developed a comprehensive system for managing all types of spinal cord injuries and spinal cord problems. The Committee concluded that to exclude any form of spinal cord disorder, congenital or acquired, would result in a lack of completeness in dealing with the problem.

The Committee concluded that the Commonwealth should fund, through legislation, a spinal cord panel designated to develop and promote a comprehensive system of care. The panel would certify certain institutions as spinal cord centers and monitor their activities in order to assure the best possible care at the most reasonable cost. Providing efficient service for total care necessitates limiting the number of spinal cord centers to those areas where the need is justified.

Difficulties involved in reporting disease and injury classifications confine this report to the patient with traumatic spinal cord injury. Restricting the study to a single frame of reference makes possible the comparison of Pennsylvania's data with that of other areas. The statistics included from Pennsylvania are only those of spinal cord injury with permanent paralysis. For the most part these signify quadriplegia and paraplegia.

Although its statistics are based only on traumatic damage, the Committee proposes that *all* patients with spinal cord damage will benefit from this comprehensive program.

The Committee's areas of investigation have encompassed statistical data; retrieval and transportation of the injured patient; acute care facility and equipment; rehabilitation centers; long term followup in satellite centers for outpatients; alternative housing; education; and research.

The problem

Each year 11,000 Americans, the majority between the ages of 18 and 35, suffer traumatic spinal cord injuries with resultant permanent paralysis of varying degrees. Estimates of the number of disabled range from 125,000 to the National Paraplegia Foundation's approximation of 250,000.

In a study published in December 1976, the Insurance Institute for Highway Safety (Washington, DC) found that each year "the spinal cords of some 5,300 Americans are severed, crushed, or otherwise seriously injured in motor vehicle crashes *alone*."[1] When football, diving, and other sports-related accidents; falls; industrial and occupational accidents; and gun shot wounds are added to automobile accidents, the figures are staggering.

Medical expenses now average $40,000 in the first year. The lifetime expectation for medical costs is $600,000 per individual. Our gross national product suffers an estimated loss of $1.2 million per case.

Table I

Incidence of Spinal Cord Injury from Trauma
Commonwealth of Pennsylvania 1973-1974

	Spinal Cord Injuries no bone injury	Spinal Cord Injuries with bone injury	Totals
Deaths	401 26	240 16	641 42
No. Patients needing Rehabilitation	375	224	599

Hospitals surveyed—265
Hospitals responding—186
Percent response—70%

Of the 79 ***not*** *responding, 40 were in the densely populated areas of the southeast and southwest (the Philadelphia and Pittsburgh areas)—areas that have high occurrence of spinal cord injury*

Current status in the commonwealth

Pennsylvania has no system for the management of spinal cord injury services. Many victims are taken to small hospitals with inexperienced staffs or to institutions without appropriate facilities and personnel. In many instances, although competent centers provide acute care, comprehensive rehabilitation and education and long term followup are not available. This non-system often results in limited skills, a depressing life existence, and total dependence on repetitive hospitalization and welfare.

Early treatment in institutions with specialized personnel and equipment may prevent further injury and hence save a significant group of people from the specter of permanent paralysis. Results of our studies suggest that the majority of victims can be rehabilitated and employed at high levels of function and responsibility.

Presently, not one four-year college or university in Pennsylvania is equipped to handle the paraplegic student for a full college education. This deplorable fact forces residents of the Commonwealth to refer to other states.

Appalled by the absence of a system for managing these patients, the Committee offers its proposal for a comprehensive system for the management of spinal cord injury services. Implementation of this proposal will require funding the Committee as a base for establishing spinal cord centers throughout Pennsylvania. The remainder of this report delineates the areas to which effort must be directed.

Statistical data

An attempt to determine the number and location of spinal cord injuries in Pennsylvania has consumed two years of time and effort. Despite a multiple method approach, the difficulty in procuring a sufficient number of responses reduced the findings to approximations only.

William Steinbach, M.D., Paul Ferguson, M.D., and our consulting statistician, Mr. Ed Zerdy of the Pennsylvania Department of Health, have gathered data which we are reasonably certain give an accurate sampling from which to draw significant conclusions.

While the Department of Health sent a detailed questionnaire to hospitals, orthopedic surgeons and neurosurgeons received the Committee's questionnaires. Through the Hospital Association of Pennsylvania (HAP) the Committee conducted a hospital survey.

Table I (drawn from the HAP study) shows the incidence of spinal cord injury from trauma in 1973-74. The footnote indicates the difficulties encountered in obtaining precise information.

The Committee encountered the same problem with all surveys attempted. Although the cost of followup procedures prohibited more definitive results, the Committee believes that, on the basis of the information received, the projections are conservative. Results of other surveys appear in the appendix.



Retrieval and transportation

The patient with acute spinal cord trauma presents a special retrieval problem. Accidents resulting in acute trauma usually occur outside the hospital environment, may involve severe problems of extrication, and often are initially handled by personnel with little expertise in clinical management. (Patients with congenital anomalies, infection processes, and other causes present less vital transportation problems.)

Unlike other illnesses, spinal cord injury requires immediate treatment at the trauma scene and enroute to the center. The initial time period is critical for the arrest of an expanding spinal cord lesion. Since much degeneration occurs during the first four hours post trauma, it is estimated that the patient should be in a qualified center within fifty minutes.

Many studies have shown that spinal cord injury can be minimized when specially trained personnel are assigned to retrieval and transportation. Rapid and closely integrated transportation services to properly equipped and staffed centers can ensure optimum treatment and prevent irreversible deterioration. Therefore, a mechanism of retrieval as outlined by this Committee is mandatory.

The current concept of care for such critically injured patients must be changed. An acutely injured person with spinal cord damage should not be sent to the nearest health facility, but should be immediately transported to the nearest spinal cord injury center.

The research reported by Maurice Albin, M.D., formulates the Committee's proposal for retrieval and transportation of the patient with spinal cord injury. The report examines all types of spinal cord injury, including lesions due to trauma, congenital anomalies, neoplasms, metabolic disturbances, and infectious processes.

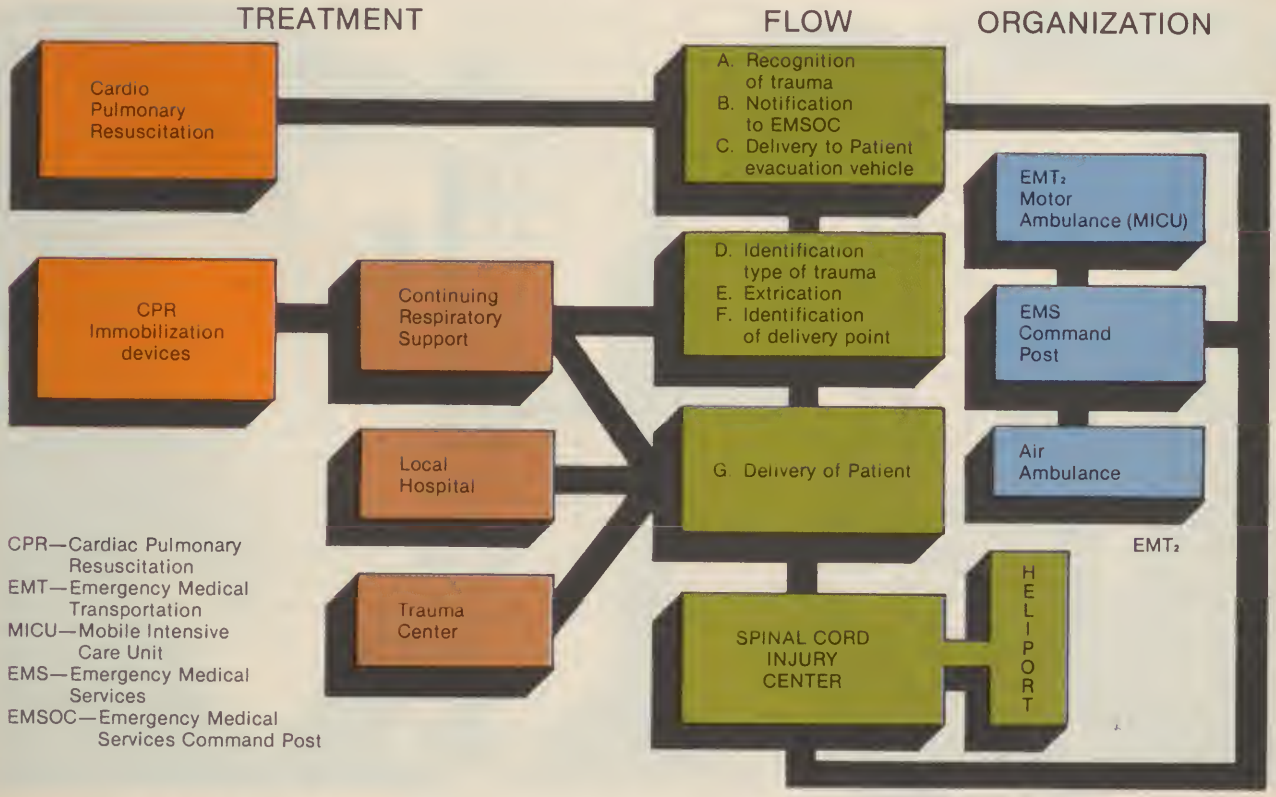
Flow pattern

The flow pattern required of an effective retrieval system (Figure 1) begins with witnesses or police units recognizing the occurrence of trauma (A) and notifying the emergency medical services command post (EMSOC) that a spinal injury may be involved (B).[2] The command post (or regional coordination center) dispatches a mobile intensive care unit (MICU) if the scene is within 50 miles of the spinal cord injury center (SCIC) or an air ambulance helicopter (AAH) if it is between 50 and 200 miles (C). In either case, the transport vehicle requires an emergency medical service technician 2 with advanced paramedic training, including intravenous infusion, ventilation and intubation, arrhythmia management, and advanced cardiopulmonary resuscitation. A specialist consultant may accompany the transport vehicle or be available if needed.

At the scene the type of trauma is identified and necessary life support activities are initiated (D). In case of entrapment, the patient is extricated using approved techniques (E);[3,4] the extent of trauma is determined (F); and, if needed, cardiopulmonary resuscitation, respiratory support, and immobilizing devices are used.

The EMSOC directs delivery of the patient to the nearest spinal cord injury center (G). Only when injuries are immediately life threatening and a local hospital is in the near vicinity will the patient be sent there or to a nearby trauma center. *Acute cord injury patients should not be routinely transported to the nearest hospital.*[5]

Figure 1 Retrieval System Spinal Cord Injury Patients



We must study ways to expedite trauma identification. To ensure efficient delivery of the patient to the appropriate center, we must improve coordination with police and emergency agencies on the city, county, and state levels. Many of the necessary ingredients are already available, including the Pennsylvania Emergency Health Services Council directed by H. Arnold Muller, M.D.; the Pittsburgh Emergency Medical Service organization; an MICU in Scranton under the direction of Patrick Ferraro, M.D., which is manned by paramedics; emergency medical training and manuals; and ambulance design and equipment adaptable to the retrieval and transportation of patients with spinal cord injury.

With these fundamental factors already present, and with our knowledge of experience in the Chicago and Baltimore Trauma Centers, organization of this portion of the spinal cord injury program is feasible.

Our standards must be high and we must formulate an intensive education and training program covering all phases of care of the spinal cord patient. This is a high priority item since at least 25 percent of those with spinal cord injury are quadriplegics—most of them between the ages of 16 and 30!

Developmental role

Because the proposed system requires a marked change in prevailing concepts of emergency medical care and transportation, the educational investment becomes as important as the material cost involved in equipping ambulances, hospitals, and rehabilitation centers.

Ample documentation shows how poorly organized, poorly trained, and poorly centralized Pennsylvania's patient retrieval and transportation system is when compared to those of many countries in the world. We must adapt the many world models[6] to the particular realities in our state. Accurate statistical data on incidence and geographical distribution of all types of spinal cord injuries will determine the number and location of specialized centers. We must, however, be concerned not only with the mechanics of setting up this system, but also with developing education and research programs that will serve our continuing efforts to provide optimum care.

Conclusions

Data indicate that the incidence of acute spinal cord injuries in Pennsylvania ranges from 30 to 50 cases per million inhabitants. Projecting this figure to our knowledge of first year costs, we are talking of an expenditure of about $2 million per million inhabitants or approximately $24 million annually. This figure does not take into account the sociological problems and suffering encountered by the family and community of the injured person. Thus our goal must be to identify the patient and transport him without delay to the nearest treatment facility without exacerbating his condition. The links of this chain of action must be equally strong, for proper retrieval and transportation procedures have little value when treatment facilities are inadequate.

Spinal cord injury centers

The Committee's review of statistics on current facilities in Pennsylvania's hospitals discloses the need for regional centers that are properly administered, coordinated, and supervised.

The Committee is convinced that SCICs must care for a significant patient load in order to maintain their expertise. Facilities must also be comprehensive enough in terms of equip-



ment and personnel to handle all possible complications and alternative forms of therapy.

It is the judgment of the Committee that five such centers, in conjunction with satellite hospitals, would adequately serve the needs of the Commonwealth.

Prior to activating each proposed center, plans should be drawn up and budgets estimated so that a single center need not possess all basic requirements, even where definitive need is established. Expensive, infrequently used resources will be centralized, increasing efficiency and cost economy, avoiding duplication of services, and decreasing premature death or lifelong dependency on existing, inadequate facilities.

Jewell L. Osterholm, M.D. compiled the elements which constitute the Committee's conception of a spinal cord injury center.

Patient load

A center should care for at least 30 to 50 patients yearly. When patient loads fall below this level, expertise, efficiency, and interest can be expected to decline in direct proportion to the population. Larger patient loads are possible when facilities and personnel exist to achieve success. These considerations will largely determine the geographical locations selected.

Personnel

Hospital care alone may involve an estimated 25 medical and ancillary specialists.

An acute spinal injury center must have a fused working team consisting of the following professional components: *Surgery*—general, neurological, orthopedic, cardiothoracic, urological, and plastic; *Medicine*—general, pediatric, pulmonary, and infectious disease; *Other*—anesthesiology, neurology, neurological nursing (spinal injury), psychiatry, psychology, rehabilitation, critical care, intermittent bladder catheter team, social services, and a functioning house staff. The necessity for these elements can scarcely be overemphasized.

Facilities

Required facilities should include: an emergency room, fully equipped to process all types of acute care cases; an operating room, immediately available at all times; a radiology department, capable of rapid diagnosis in any hospital area; a critical care unit, with appropriate monitoring devices; and acute care laboratory for blood gases, chemistry, and cytology, available on a 24-hour basis; a spinal injury unit for acute and chronic cases.

These facilities should be geographically distinct, and each should be available and equipped for proper management of the spinal cord injury victim.

Equipment

Necessary equipment should include: all standard operating room equipment, including a microscope and a full array of microsurgical instruments; all general radiographic equipment plus polytomography (which enables air and/or oil myelography); and spinal injury beds with traction and halo frames.

Additional specialized equipment should include: sensory evoked potential equipment (an electrophysiological methodology that is rapidly becoming state-of-the-art in diagnostic and treatment arenas); an intra-operative hypothermic unit; monitoring equipment used for electrocardiograms, blood pressure, and respiration on line with oscilloscopic display with appropriate alarm systems; and modern cystometric equipment.

Communications equipment should include identical record-keeping techniques in all centers and radio communications (telemetry) with the paramedical team.

Teaching

Centers must be charged directly with teaching responsibilities at professional and technical levels. The best current treatment and care methodologies must be relayed, and handbooks should be compiled. The centers should also train paramedical and nursing personnel and offer fellowships in acute and chronic care.

Research

Clinical investigation of improved care methodologies is implicit in the concept of a spinal injury center. Detailed records from each center must be available to assess comparable care standards and results and to allow prediction of the therapeutic potency of a new treatment modality. Peer review will be effective in the maintenance of high standards.

Centers must be so constituted that new methods discovered in the laboratory can be applied in rigidly controlled experimental programs. Rapid advances in improved methodology and techniques must be incorporated as they occur.

The Committee believes that research in the field of spinal cord injury must be enthusiastically supported at selected centers to improve the recovery potential of victims of this catastrophic illness. Not all centers can be involved in basic research, but all should be involved in clinical research.

Rehabilitation

Victims of spinal cord injury are often immobilized for weeks in acute hospitals before being transferred to chronic care institutions that are poorly equipped to handle their special needs.

American, British, and Swiss SCICs have demonstrated that the majority of patients with spinal cord damage can have a useful and productive future given the necessary specialized care and early aggressive rehabilitative measures. Only a small percentage of spinal injured persons are not candidates for an effective restorative program.

Rehabilitation is the cornerstone of the patient's lifetime productivity. Rehabilitative measures must be started early and must involve totally the patient and his family. Further, they must continue until the individual's needs and abilities reach complete rehabilitation.

Preventive rehabilitation must be first, striving to eliminate early complications and further loss of spinal cord function. Professor Marion Weiss of the Rehabilitation Institute of Warsaw, Poland, estimates that treatment for complications, and not the injury itself, can add from three to nine months to the patient's total hospitalization. The rehabilitative process



then extends to adaptation to a changed world and to vocational training.

Thus our recommendation for rehabilitation programs includes inpatient and outpatient care, home health care, vocational rehabilitation, and long term placement for the severely disabled (see Table II).

Dorthea Glass, M.D., Mr. Michael Goodling, and Mrs. Elizabeth McCann formulated the following plans for comprehensive rehabilitation.

Basic premises

A basic premise of managing the spinal cord injury patient is that the rehabilitative process must begin as soon as his medical condition is stabilized and while he is still in bed or on a frame. When the acute crisis subsides emphasis is transferred to restoration of lost function and to reduction of complications accompanying the paralytic state (see Table III).

Proximity of the acute rehabilitation unit to the acute hospital is desirable, for setbacks often interrupt the rehabilitative process and require return to an acute hospital. Long term rehabilitation facilities should be as close as possible to the patient's home community.

Under the proposed program of SCIC, specialized care can be continued; and, as its need subsides, the rehabilitation and self-care phases of treatment can be progressively increased. Periodic return to the acute care center may be necessary, but integrated centers minimize disruption in the rehabilitative process.

A comprehensive continuum of services on the in- and out-patient levels, and a cooperative working relationship between the two is needed because the patient will use both at different stages in his rehabilitation program. The family must be involved in the program early and remain an integral part throughout its phases (see Table IV).

Maximum rehabilitation further necessitates multi-disciplined specialists extending from the acute to the subacute to the chronic—and from the institutional setting back into the community and home.

Rehabilitation units must be able to deal with a broad range of physical, psychological, and social problems.

Physical problems

The physical problems of the spinal cord injury patient include bladder and bowel incontinence, diminished strength and range of motion, impaired respiratory capacity and temperature regulation, skin breakdown, decreased sensation, paralysis or paresis, edema, spasticity, pain, limitations of physical endurance, altered sexual functioning, susceptibility to infection, and decreased appetite.

(continued on page 43)

Table II

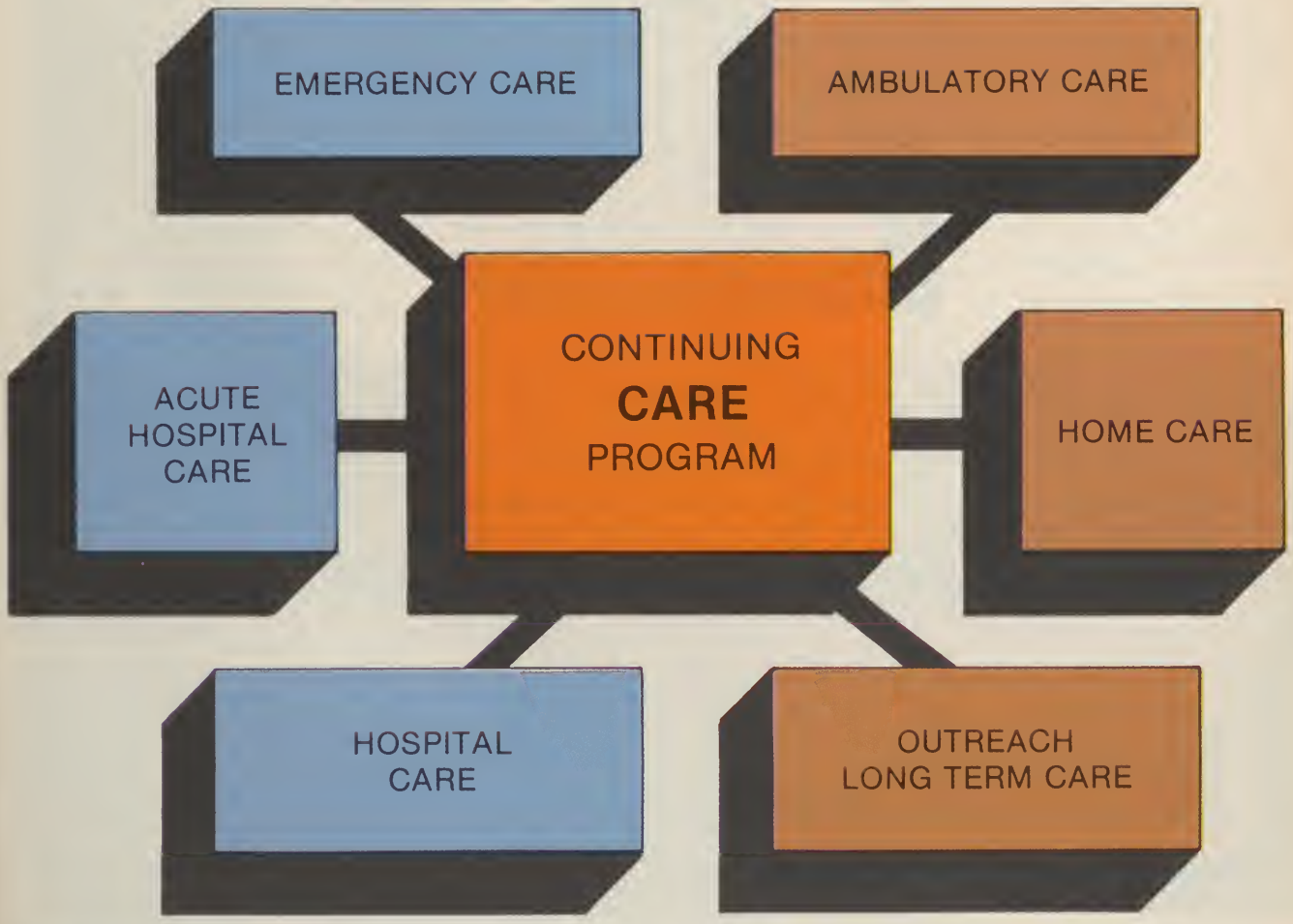


Table III

Criteria for Transfer
to Local Post-Acute Rehabilitation Program

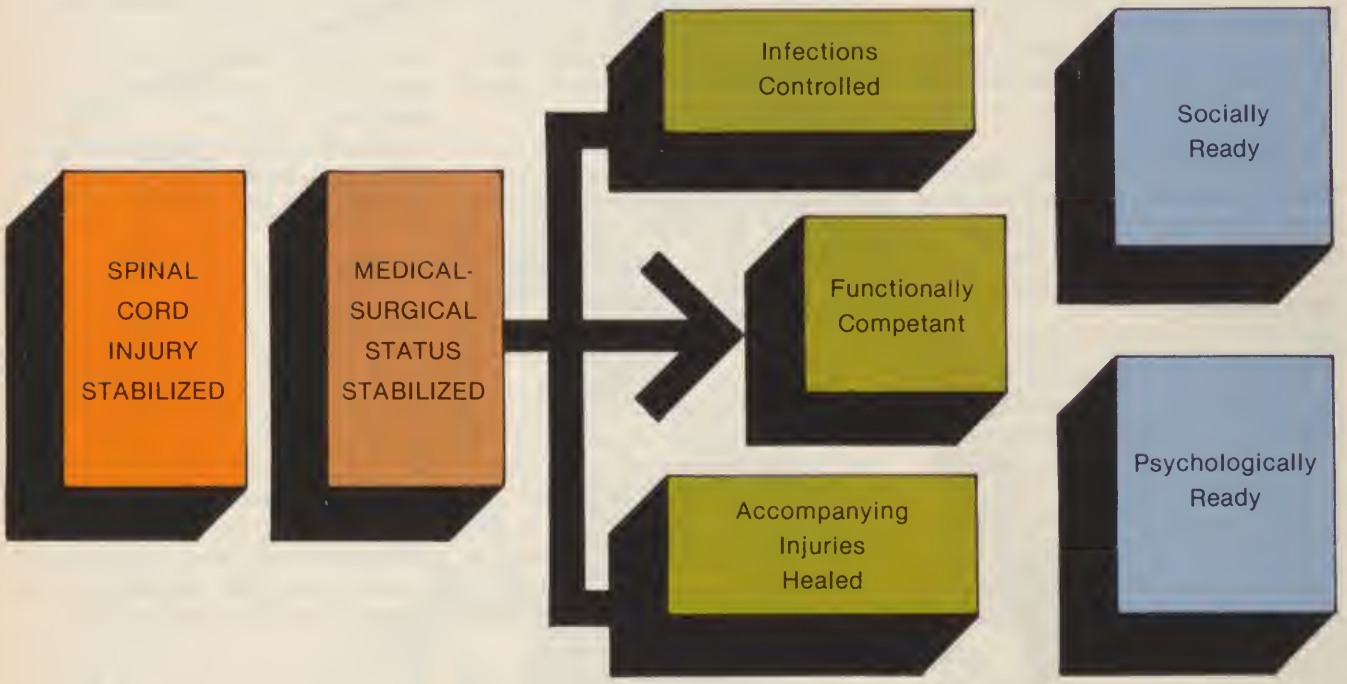
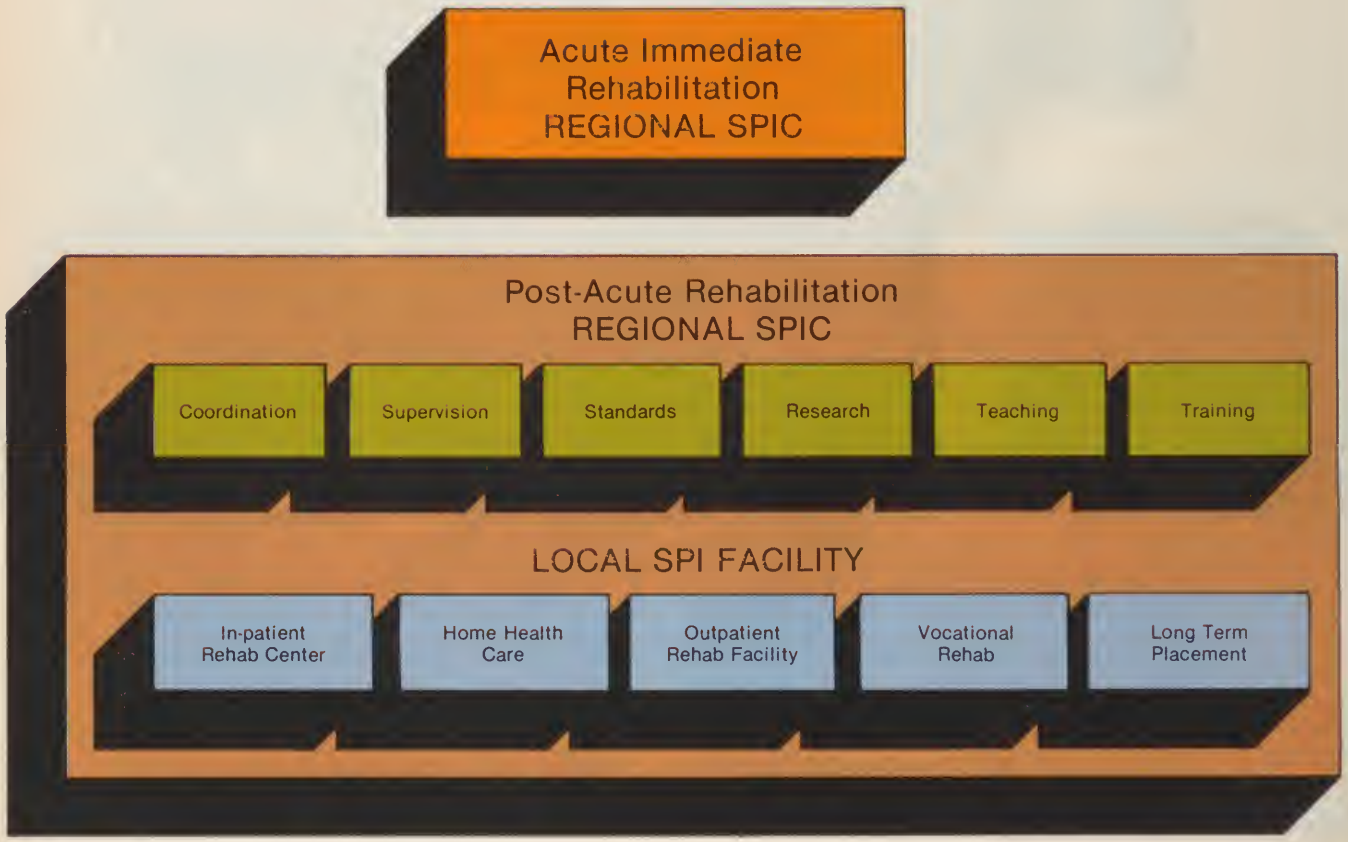


Table IV

Rehabilitation Care
for the Spinal Cord Injury Patient





Does it influence your choice of a peripheral/cerebral vasodilator*?

- Vasodilan—compatible with coexisting diseases
- Vasodilan—compatible with concomitant therapy
- Vasodilan—compatible with your total regimen for vascular insufficiency

***Indications:** Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Vasodilan injection, isoxsuprine HCl, 5 mg., per ml.

Dosage and Administration: Oral: 10 to 20 mg., three or four times daily.

Intramuscular: 5 to 10 mg. (1 or 2 ml.) two or three times daily. Intramuscular administration may be used initially in severe or acute conditions.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Parenteral administration is not recommended in the presence of hypotension or tachycardia.

Intravenous administration should not be given because of increased likelihood of side effects.

Adverse Reactions: On rare occasions oral administration of the drug has been associated in time with the occurrence of hypotension, tachycardia, nausea, vomiting, dizziness, abdominal distress, and severe rash. If rash appears the drug should be discontinued.

Although available evidence suggests a temporal association of these reactions with isoxsuprine, a causal relationship can be neither confirmed nor refuted.

Administration of single dose of 10 mg. intramuscularly may result in hypotension and tachycardia. These symptoms are more pronounced in higher doses. For these reasons single intramuscular doses exceeding 10 mg. are not recommended. Repeated administration of 5 to 10 mg. intramuscularly at suitable intervals may be employed.

Supplied: Tablets, 10 mg., bottles of 100, 1000, 5000 and Unit Dose; Tablets, 20 mg., bottles of 100, 500, 1000, 5000 and Unit Dose; Injection, 10 mg. per 2 ml. ampul, box of six 2 ml. ampuls.

U.S. Pat. No. 3,056,836

VASODILAN®

(ISOXSUPRINE HCl)

20-mg tablets

Mead Johnson PHARMACEUTICAL DIVISION

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This asthmatic isn't worried about his



next breath...

he's active
he's effectively
maintained on

QUIBRON®

Each capsule or tablespoonful (15 ml) elixir contains theophylline (anhydrous) 150 mg and glyceryl guaiacolate (guaifenesin) 90 mg. Elixir: alcohol 15%

high theophylline for effective around-the-clock therapy

Quibron may give the asthmatic up to eight hours of bronchodilation with each dose and provides the high dosages of theophylline which are now believed necessary to keep patients free of acute attacks and chronic wheezing.

100% free theophylline

Quibron helps achieve high serum theophylline levels with minimal dosage volume...delivers 100% free theophylline in comparison to many other compounds which contain from 47% to 91% effective theophylline.

individualized theophylline dosage schedule

Today's more efficient usage of theophylline includes individualizing dosage and monitoring serum theophylline levels. The usual recommended dosages of Quibron are: Adults—1 to 2 capsules or tablespoonfuls every 6 to 8 hours; dosage may be cautiously adjusted upward when necessary to a maximum of 2000 mg theophylline per 24 hours. Children under 12—4 to 6 mg theophylline per kg/body weight every 6 to 8 hours; dosage may be cautiously adjusted up to 9 or 10 mg/kg every 6 hours.

Now, for the asthmatic who requires high-dose theophylline therapy for therapeutic serum concentrations

Mead Johnson Pharmaceutical Division announces

QUIBRON®-300

Each capsule contains 300 mg theophylline (anhydrous) and 180 mg glyceryl guaiacolate (guaifenesin)

For Brief Summary, please see the last page of this advertisement.

QUIBRON®-300

Each capsule contains 300 mg theophylline (anhydrous) and 180 mg glyceryl guaiacolate (guaifenesin)

The new high-dose theophylline capsule... for dependable theophylline therapy when products of lower dosage do not adequately control asthma symptoms.

Specially formulated

...for optimal efficacy

Quibron-300 is appropriate therapy for asthma patients whose symptoms are not adequately controlled on lower doses of theophylline, particularly for patients whose theophylline dosage has been adjusted upward to achieve therapeutic serum levels. In one study,[1] an average peak increase in FEV_1 of 35% was demonstrated after a single dose equivalent to one Quibron-300 capsule, and significant improvement in this pulmonary function lasted for nearly eight hours after administration.

...for optimal predictability

One Quibron-300 capsule q6–8h yields therapeutic serum levels (10–20 mcg/ml) in many adults. With a single dose, more than 75% of patients achieved serum levels potentially providing clinical benefit (5–15 mcg/ml). Half-life of theophylline varies widely from patient to patient, making monitoring of theophylline therapy important. Patient response may be monitored clinically if blood levels are not available as long as dosage does not exceed 1200 mg in 24 hours for adults.

...for optimal dosage convenience

The simple, convenient dosage of new Quibron-300—one capsule every six to eight hours—makes it easy for patients to comply with high-dose regimens often required to achieve therapeutic serum levels. Quibron-300 capsules may provide maximum therapeutic value with maximum convenience. In fact, the switch from a low-dose to a high-dose regimen may be accomplished by merely switching capsules, by stepping up to Quibron-300 capsules.

...for minimal theophylline side effects

Adverse reactions to theophylline are related to serum levels and are usually not a problem at concentrations below 20 mcg/ml. Of 45 patients studied[1] after a single dose, only seven reported adverse reactions. The most common reaction was a feeling of lightheadedness by three of these seven patients.

Reference 1. Data on file. Mead Johnson Pharmaceutical Division.

Indications: For the symptomatic treatment of bronchospastic conditions such as bronchial asthma, asthmatic bronchitis, chronic bronchitis, and pulmonary emphysema.
Dosage: Quibron—Adults: 1-2 capsules or 1-2 tablespoonfuls elixir every 6-8 hours. Children under 12: 4-6 mg theophylline/kg body weight every 6-8 hours.
Quibron-300— Adults: 1 capsule every 6-8 hours.
Theophylline dosage may be cautiously increased to 2000 mg/24 hour in adults and 9 or 10 mg/kg every 6 hours in children. Monitoring of serum theophylline levels at higher dosages is recommended.
Precautions: Do not administer more frequently than every 6 hours, or within 12 hours after rectal dose of any preparation containing theophylline or aminophylline. Do not give other xanthine derivatives concurrently. Use in case of pregnancy only when clearly needed.
Adverse Reactions: Theophylline may exert some stimulating effect on the central nervous system. Its administration may cause local irritation of the gastric mucosa, with possible gastric discomfort, nausea, and vomiting. The frequency of adverse reactions is related to the serum theophylline level and is not usually a problem at serum theophylline levels below 20 μg/ml.
How Supplied: Quibron Elixir: Bottles of 1 pint and 1 gallon. Quibron Capsules: Bottles of 100 and 1000 and unit-dose packs of 100. Quibron-300 Capsules: Bottles of 100.

Mead Johnson PHARMACEUTICAL DIVISION

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MJL 7-4280

Psycho-social problems

In addition, the victim is faced with severe psychological and social problems. Profound depression is his immediate reaction. Adjusting to his disability, his future vocational limitations, and his impaired body image is an acute process. His role in life is reversed from independence to almost complete dependence. Fears beset him—sexual limitations, financial uncertainty, and lack of acceptance by family and community.

He requires specialized assistance as he adjusts to a changing physical lifestyle and to the educational and training requirements of his disability. Regardless of his previous strengths he now needs intensive interest and support as he struggles through the stages of social reintegration.

Requisite facilities

Effective physical restoration programs require a wide range of equipment and facilities. While the patient is still immobilized, many tools can be useful in motivating him to take an active part in his own care. Once wheelchair tolerance is achieved, more intensive therapy, requiring architecturally accessible dressing, bathing, grooming, and therapy areas is possible. Braces, appliances, prosthetic devices, and therapeutic pools are but a few of the valuable aids to rehabilitation. As early as possible, self-help toward a daily living program is instituted (see Table V).

Personnel

Rehabilitative equipment must be accompanied by expert guidance in retraining the patient's muscles and mind. Consequently, a team of qualified professionals is essential. Such a team should include physiatrists, physical and occupational therapists, rehabilitation nurses, and certified orthotists. Psychological-vocational counselors, social workers, and dietitians provide additional necessary support. Table VI suggests effective ratios of professionals per patient.

Program

Important features of the program include:

- Early training of the active and passive ranges of motion;
- Bed positioning to prevent decubitus and contractures;
- Sensory and coordination evaluation and treatment;
- Using tilt boards to adapt to an erect position;
- Wheelchair training, transfer, and management;
- Ambulation training;
- Progressive training with bracing;
- Psycho-social counseling for the patient and his family;
- Daily living skills activities;
- Family instruction in home care;
- Followup program with community rehabilitation agencies.

Table V

Facilities and Equipment
for Acute Immediate Care





Outreach program

As the need for acute care diminishes, an ambulatory outpatient rehabilitation services program is integrated into the continuum of care. Services are now closer to the patient's home setting. A broad range of support services with strong family orientation bridges the gap between institutional and "real" life. As the need for specialized medical-surgical care decreases, emphasis is placed on basic elements essential to maintaining physical status and continuing therapy.

Important ingredients in the transition stage are physical therapists working in the home environment, occupational therapists to adapt devices to the home setting and train the patient in their use, and home health aids for the severely disabled to relieve family members in nursing procedures.

Housing, transportation, recreation, and vocational retraining services (either in the community setting or attached to inpatient rehabilitation centers) are also necessary. Development of barrier-free settings, information and referral support services, economic security, and public education completes the list of optimum components in the program to help the severely disabled return to satisfying, productive lives. When such individuals lessen their reliance on welfare and institutional help, they will lower their long-range cost and increase their contributions to society.

Housing alternatives

Lack of adequate housing arrangements restricts many physically disabled persons from reaching full potential, regardless of the scope of their rehabilitation efforts. Unsuitable residences prevent them from reestablishing their independence. Too often, the physically handicapped must reside in an institution which denies them the opportunity to lead productive, enjoyable lives.

Alternative housing must be developed in order to achieve the total rehabilitation aims for victims of spinal cord injury. Michael Goodling, occupational therapist at the Harrisburg Polyclinic Hospital, has researched housing alternatives to institutional care.

In the final phases of rehabilitating the spinal cord injured individual the goal must be his reintegration into the community and his reestablishment as a contributing member of society. Where and how he can live and function with dignity is the first problem to be solved. Not all such persons, regardless of the degree of their disability, can or should live with their families indefinitely.

The progression of events has led the victim through the original trauma and the retrieval system, through intensive care and the rehabilitation center. Although he is medically and psychologically ready to leave the center as a functionally independent individual, he has nowhere to live but in an institution which enforces dependency. Consequently, he forfeits his rehabilitation gains.

In this cycle, not only are rehabilita-

Table VI

Acute Immediate Care Personnel Requirements

	Ratio Personnel to Patients	
Physiatrists	1	15-20
Physical Therapists	1	8
Occupational Therapists	1	8
Social Services	1	25
Psychologists	1	25
Rehabilitation Nurses	1	2
Recreation Therapist	1	per unit

Additional Personnel	
Therapeutic Dietitian	Intermittent Catheterization Team (technicians or nurses) (available on the premises or by consultation)
Urologist	
Orthotist	

tion goals lost, but many times, the individual is lost, as are the monies used to sustain him. Alternative solutions must be provided. A paraplegic girl, commenting on the social isolation caused by architectural barriers, pictures herself as "a veritable vegetable trapped in a back room up two flights of stairs." A high level quadriplegic whose family and friends could not handle his attendant care needs felt that he was "doomed to rotting in a nursing home for the rest of (his) life."

Per diem rates charged by nursing homes to such an individual (or more often to a subsidizing agency) range from $25 to $38 in the Dauphin, Cumberland, and York County areas and are significantly higher in metropolitan areas such as Pittsburgh and Philadelphia.

Accessible housing in the community could decrease the per diem costs. Examples include the motel-like cooperative group residence of the Christian League for the Handicapped in Wisconsin which costs about $5 per day, and the commune-like transitional halfway houses for high level quadriplegics, such as the Texas Institute of Rehabilitation and Research and the University of Illinois, which cost between $8 and $15 per day.

In a comprehensive report on the subject, Frederick A. Fay[7] outlines subjective and objective views of the housing problem. He reports of housing alternatives that must meet the requirements of both the rehabilitation professional and the rehabilitated person before they are considered acceptable. These requirements include: cost, support services, size, level of dependence, funding, financial orientation, effectiveness of evaluation, degree of community integration and vocational productivity, locus of management control, resident's self-image, wheelchair accessibility, resident mobility, residential privacy, personal space, and overall orientation.

Two workable alternatives to the housing problem appear: accessible group residences and totally accessible residences for individual living.

In general, group residences are viewed primarily as "transitional halfway house" links in the overall spinal cord injury management system. Thus, for most paraplegics and quadriplegics, the group residence is a stepping stone into the general housing community. Yet less than one percent of the general housing in our country has wheelchair accessibility defined both as level or ramped entrance and as possessing a sufficiently wide bathroom door.

Fay summarizes current research on the first housing alternative:

Solution A: Group Residences-Three distinct groups appear to benefit by some sort of group residence (hostel, halfway house, motel, dormitory, clustered housing, congregate housing, commune, etc.). First, many high level quadriplegics (C2-C4) may require skilled nursing as well as housekeeping and attendant care and have found sharing the costs, rent, maintenance, and help with other quads to be quite economical. Second, many paraplegics and quadriplegics who benefit by the peer therapy of the spinal cord injury center, but who no longer need the costly support services, have found great benefit in transitional halfway houses that bridge the gap between hospital dependency and community self-sufficiency, as described above. Third, there are a small minority of persons with spinal cord injury who simply prefer life in a community of disabled individuals or feel that a specialized facility is better than no facility.

Accessible group residences are a practical answer to the handicapped

individual's needs. Aside from the three group residences previously mentioned, Creative Living in Columbus, Ohio and Help Unite Human Relations in Topeka, Kansas are excellent examples.

The second alternative is summarized by Fay as follows:

> *Solution B:* Total Accessibility-Nearly every paraplegic and many quadriplegics can live in virtually any housing alternative that is accessible to them—from log cabin to penthouse. Generally, these persons prefer to be totally integrated into their community. After reviewing the literature on housing for the disabled around the world, it seems obvious that the ultimate goal in changing our housing must be a barrier-free environment that is totally accessible to all, including persons with spinal cord injury who have mobility limitations!

The need for barrier-free architecture has been well documented. The National Commission on Architectural Barriers reported in 1967:

> The modern man-made environment is designed for the young and healthy, yet almost everyone, sooner or later, is handicapped by a chronic or temporary disability or by the infirmities of old age. By designing for the ideal human body, we bar others from getting an education, earning a living, becoming a part of active community life. More than 20 million Americans are built *out* of normal living by unnecessary barriers: a stairway, a too narrow door, a too high telephone.

A comprehensive summary of housing and home services for the disabled in the United States is reported in the *Rehabilitation Gazette* by G. Laurie:

> Housing for the disabled is not merely a place of residence. Housing has become a blanket word for the problems of education, training, employment, transportation, architectural barriers, recreation, attendant care, and living arrangements. Because of the complexity of individual differences, there must be many choices: services brought into the home, shared apartments, transitional arrangements, adaptation of existing dwellings, provisions for a percentage of disabled and elderly in future apartments and 'new towns,' and a range from apartments to mobile homes, from insurance plans to nursing home wings, day care centers, and foster homes.
>
> Millions of dollars are being wasted in maintaining severely disabled people in civilian hospitals and nursing homes. A majority of these individuals could live happily and productively in more imaginative situations for a fraction of the cost of any institution if some assistance and services were provided.[8]

At this writing, there are no wheelchair accessibility standards that are rigidly enforced in the Commonwealth of Pennsylvania—nor is there any group housing available. A newly established advisory Architectural Barrier Compliance Board has, however, begun to review accessibility standards.

The Committee believes that investigation into provisions for properly accessible housing is an integral part of the final stages of rehabilitation.

Education for the handicapped

Advanced educational opportunities for the wheelchair-bound student are pitiful in Pennsylvania. For those disabled individuals who are capable of college level work, any rehabilitation process logically extends to an academic program of one of the Commonwealth's post-secondary institutions.

The sorry fact is that not a single four-year state college or university is totally accessible or prepared to properly handle the disabled student in order that he may earn a baccalaureate degree.

It should be understood that the reason for this sad situation is not that information is unavailable for the adaptation of the needed facilities. The National Easter Seal Society in Chicago has made available architectural barrier kits which contain published material on barrier-free design and specialized guides to implement community action programs.

John W. Clokey, dean of the School of Arts and Letters at West Chester State College, is wheelchair-bound and has researched the meager facilities available in Pennsylvania for the severely handicapped student.

Although the state's community and junior colleges are accessible for the handicapped, the two-year programs of these schools are designed for the student who can commute.

Two years ago the secretary of education, the Honorable John C. Pittenger, designated the state colleges at West Chester, Edinboro, and Cheyney as educational centers to be renovated to accept the disabled. But no funds have been provided for the necessary accommodations or staff.

Edinboro State College, using what funds it could spare for this purpose, has made truly commendable efforts and currently is attempting to aid some forty wheelchair-bound students in their efforts to earn baccalaureate degrees. At West Chester and Cheyney only the newer buildings are accessible; no residence halls are satisfactory.

The three state-related universities (Pittsburgh, Penn State, and Temple) have made some efforts to handle the handicapped, but they also are hampered by the lack of funds.

Consequently, the vast majority of our disabled residents must go out of the state for higher education.

This Commonwealth should, at the very least, fund designated colleges and universities to educate the able wheelchair-bound individuals. The state's departments of education and labor and industry have the knowledge to plan wisely and efficiently. Aggressive leadership in the legislature is greatly needed to develop and ensure adequate appropriations. It remains for Pennsylvania to catch up to other states in this neglected area.

Conclusions

The absence of a comprehensive system to identify, transport, treat, rehabilitate, and educate spinal cord injury patients in the Commonwealth of Pennsylvania has been demonstrated statistically. This deficiency is costly in human suffering, in productivity, and in dollars.

Our estimated minimum *first year* cost of the 700 annual injuries in Pennsylvania currently averages $28,000,000—a loss which is added to the cost of existing cases.

We conclude that the development of a state-wide network to manage vic-

tims of spinal cord injuries and other spinal cord dysfunction is long overdue and can correct the present situation in which care is at best uncoordinated, and at worst nonexistent.

We note that rehabilitating and educating these victims to participate more fully in our society can provide tax flow from this group as they become reemployed, helping to reduce the cost of developing this proposed system.

Duplication of services is not anticipated. Wherever possible, coordination into present systems is planned, with satellite hospitals serving as evacuation points to concentrated centers strategically situated throughout the state.

This proposal is neither innovative nor pace-setting. Rather, it is a solution that will enable the Commonwealth to catch up to at least seven other states in the nation and to Great Britain, Switzerland, and Australia, who are years ahead in this area.

We conclude that emergency medical care is not enough. Acute hospital care is not enough. Rehabilitation centers and followup are not enough. These ingredients are all vital, but a progressive integration of these elements through a unified, complete care system provides the only method of ensuring the continuity of care required to reduce the costs that are so enormous in proportion to the incidence of spinal cord injury.

Recommendations

Therefore, we strongly recommend:

1. That the Spinal Cord Injury Committee be reestablished under the Secretary of Health of the Commonwealth of Pennsylvania by an act of legislation to implement the development of a system as outlined in this report;

2. That a sum of two (2) million dollars be allocated by legislation for implementation of this proposal over a two-year period;

3. That the Committee use these funds to (a) acquire an adequate full-time staff; (b) provide transportation for the volunteer committee members; (c) provide for educational and developmental "seed money" to approved applicant institutions;

4. That the Committee be enabled to certify and approve Spinal Cord Injury Centers;

5. That the Committee establish a mechanism for monitoring patient care, education, and research; and

6. That legislation be developed to make available facilities for handicapped individuals at educational institutions consistent with nondiscriminatory provisions of section 504 of the Rehabilitation Act of 1973.

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Recommendations and Conclusions

Conclusions

The absence of a comprehensive system to identify, transport, treat, rehabilitate, and educate spinal cord injury patients in the Commonwealth of Pennsylvania has been demonstrated statistically. This deficiency is costly in human suffering, in productivity, and in dollars.

Our estimated minimum *first year* cost of the 700 annual injuries in Pennsylvania currently averages $28,000,000—a loss which is added to the cost of existing cases.

We conclude that the development of a state-wide network to manage victims of spinal cord injuries and other spinal cord dysfunction is long overdue and can correct the present situation in which care is at best uncoordinated, and at worst nonexistent.

We note that rehabilitating and educating these victims to participate more fully in our society can provide tax flow from this group as they become reemployed, helping to reduce the cost of developing this proposed system.

Duplication of services is not anticipated. Wherever possible, coordination into present systems is planned, with satellite hospitals serving as evacuation points to concentrated centers strategically situated throughout the state.

This proposal is neither innovative nor pace-setting. Rather, it is a solution that will enable the Commonwealth to catch up to at least seven other states in the nation and to Great Britain, Switzerland, and Australia, who are years ahead in this area.

We conclude that emergency medical care is not enough. Acute hospital care is not enough. Rehabilitation centers and followup are not enough. These ingredients are all vital, but a progressive integration of these elements through a unified, complete care system provides the only method of ensuring the continuity of care required to reduce the costs that are so enormous in proportion to the incidence of spinal cord injury.

Recommendations

Therefore, we strongly recommend:

1. That the Spinal Cord Injury Committee be reestablished under the Secretary of Health of the Commonwealth of Pennsylvania by an act of legislation to implement the development of a system as outlined in this report;
2. That a sum of two (2) million dollars be allocated by legislation for implementation of this proposal over a two-year period;
3. That the Committee use these funds to (a) require an adequate full-time staff; (b) provide transportation for the volunteer committee members; (c) provide for educational and developmental "seed money" to approved applicant institutions;
4. That the Committee be enabled to certify and approve Spinal Cord Injury Centers;
5. That the Committee establish a mechanism for monitoring patient care, education, and research; and
6. That legislation be developed to make available facilities for handicapped individuals at educational institutions.

Appendices

HOSPITAL UTILIZATION PROJECT PITTSBURGH, 1974

State of Pennsylvania

Spinal Cord Lesion without evidence of spinal bone injury	958
Fracture and fracture dislocation of vertebral column with spinal cord lesion	806
Total	1765

QUESTIONNAIRE to ORTHOPEDIC SURGEONS

Spinal cord injuries reported	560
Permanent neurological loss	136
Paraplegics	56
Quadriplegics	33

310 questionnaires sent
100 replies

ICDA CODES

806	Fracture and fracture dislocation of vertebral column with spinal cord lesion
806.0	Cervical, closed
806.1	Cervical, open
806.2	Dorsal (thoracic) and lumbar, closed
806.3	Dorsal (thoracic) and lumbar, open
806.4	Sacrum and coccyx, closed
806.5	Sacrum and coccyx, open
806.6	Unspecified, closed
806.7	Unspecified, open
806.9	Late effect, any vertebra

These codes are applicable to all the following tables

	8060	8061	8062	8063	8064	8065	8066	8067	8068	8069	TOT.
ALLEGHENY	7	23	13	35						141	219
ARMSTRONG										1	1
BEAVER			1							1	2
BERKS	10		12		1					5	28
BLAIR			1								1
BRADFORD			2		2						4
BUCKS	1		4	1							6
CAMBRIA	7		4							9	20
CARBON			1								1
CENTRE	3										3
CHESTER			8	1	2						11
CLEARFIELD											
CLINTON									1	3	4
COLUMBIA		5									5
CRAWFORD											
CUMBERLAND	2		2								4
DAUPHIN	2		3							5	10
DELAWARE	1		8		2						11
ERIE	2	1	1			1			1	1	7
GREENE	1										1
INDIANA					1					2	3
LACKAWANNA	1		2							1	4
LANCASTER	5				2				2	4	13
LAWRENCE											
LEBANON	1		1	1							3
LEHIGH	2		2		1				1		6
LUZERNE			1		4						5
LYCOMING			2		2						4
McKEAN	1		1								2
MERCER	2		1								3
MIFFLIN			1								1
MONROE											
MONTGOMERY	7		7		5					1	14
MONTOUR	2		2								4
NORTHUMBERLAND											
PHILADELPHIA	6	1	23		4				1	18	53
POTTER											
SCHUYLKILL			8		3						11
SOMERSET	1		2							2	5
SUSQUEHANNA											
TIOGA			2								2
VENANGO											
WASHINGTON											
WESTMORELAND	8		9						1	1	19
WYOMING									1		
YORK					1						1
Total	66	25	129	38	30	1			8	195	492

ICDA CODES

958 Spinal cord lesion without evidence of spinal bone injury
958.0 Cervical, without mention of open wound
958.1 Cervical, with open wound
958.2 Dorsal (thoracic) and lumbar, without mention of open wound
958.3 Dorsal (thoracic) and lumbar, with open wound
958.4 Sacral, without mention of open wound
958.5 Sacral, with open wound
958.6 Unspecified, without mention of open wound
958.7 Unspecified, with open wound
958.9 Late effect, any part

These codes are applicable to all the following tables

	9580	9581	9582	9583	9584	9585	9586	9587	9588	9589	TOT.
ALLEGHENY	16			1	9	20	4			67	117
ARMSTRONG	1										1
BEAVER											
BERKS	4				1	4					9
BLAIR											
BRADFORD					2						2
BUCKS	4				4	1	1			2	12
CAMBRIA	5				1	1				4	11
CARBON											
CENTRE	6				2						8
CHESTER											
CLEARFIELD	1										1
CLINTON						1					1
COLUMBIA											
CRAWFORD											
COLUMBIA											
CUMBERLAND	2				3						5
DAUPHIN	9				2	8					19
DELAWARE	13			3	2	4	2			1	25
ERIE	6				2	5				1	14
GREENE											
INDIANA	2				2					1	5
LACKAWANNA	1				1	3					5
LANCASTER	4			1	2						7
LAWRENCE	1										1
LEBANON										2	2
LEHIGH	1				2		1			1	5
LUZERNE	7	1	2		6	1					17
LYCOMING	1				2	2					5
McKEAN						3					3
MERCER										1	1
MIFFLIN	2				1				2	5	
MONROE	2										2
MONTGOMERY	1		2		2	1	1			3	10
MONTOUR	7			1		2					10
NORTHUMBERLAND	1				1						2
PHILADELPHIA	31	1	6	3	8	8	2			33	92
POTTER						2					2
SCHUYLKILL	3		1		3	3					10
SOMERSET				1							1
SUSQUEHANNA	1					1					2
TIOGA	1					2					3
VENANGO					1						1
WASHINGTON										1	1
WESTMORELAND	5				4					7	16
WYOMING						1					1
YORK			1	1	4	2					8
Total	141	2	12	11	71	79	11			126	453

LENGTHS OF STAYS AND ADMISSIONS BY DIAGNOSIS

	806.0		806.1		806.2		806.3	
Ages	LOS	#	LOS	#	LOS	#	LOS	#
0-19	67.81	6	133.66	3	29.07	12	40.66	6
20-39	77.92	15	40.00	5	36.68	28	27.18	11
40-59	42.00	9	52.25	4	31.41	27	71.40	5
60 +	16.50	6	14.00	2	18.00	43	30.00	3
	56.43	36	59.85	14	26.13	110	39.60	25

	806.4		806.5		806.8		806.9	
Ages	LOS	#	LOS	#	LOS	#	LOS	#
0-19	13.50	4			37.00	1	63.65	29
20-39	7.89	9			12.20	5	22.99	91
40-59	10.25	4	5.00	1	10.33	3	39.89	39
60 +	24.50	10			20.00	2	18.41	19
	15.21	27	5.00	1	15.36	11	32.29	176

LOS = Length of stay

Codes: 806 Fracture and fracture dislocation of vertebral column with spinal cord lesion
- 806.0 Cervical, closed
- 806.1 Cervical, open
- 806.2 Dorsal (thoracic) and lumbar, closed
- 806.3 Dorsal (thoracic) and lumbar, open
- 806.4 Sacrum and coccyx, closed
- 806.5 Sacrum and coccyx, open
- 806.6 Unspecified, closed
- 806.7 Unspecified, open
- 806.9 Late effect, any vertebra

	958.0		958.1		958.2		958.3	
Ages	LOS	#	LOS	#	LOS	#	LOS	#
0-19	11.83	18	32.00	1	7.50	2	9.00	1
20-39	14.16	16	3.00	1	13.00	3	15.60	5
40-59	15.65	23			8.60	5	9.00	1
60 +	24.90	21			7.00	1		
	16.10	122	17.50	2	9.45	11	6.57	7

	958.4		958.5		958.6		958.9	
Ages	LOS	#	LOS	#	LOS	#	LOS	#
0-19	7.28	7	7.36	22	33.00	1	45.72	11
20-39	7.18	27	6.23	26	113.50	4	25.00	46
40-59	15.00	12	10.41	12	13.00	1	15.08	34
60 +	13.92	13	11.83	12			54.25	4
	10.27	59	8.20	72	83.33	6	25.08	95

LOS = Length of stay

Codes: 958 Spinal cord lesion without evidence of spinal bone injury
- 958.0 Cervical, without mention of open wound
- 958.1 Cervical, with open wound
- 958.2 Dorsal (thoracic) and lumbar, without mention of open wound
- 958.3 Dorsal (thoracic) and lumbar, with open wound
- 958.4 Sacral, without mention of open wound
- 958.5 Sacral, open wound
- 958.6 Unspecified, without mention of open wound
- 958.7 Unspecified, with open wound
- 958.9 Late effect, any part

Hospitals reporting cases having ICDA codes 806+ and 958+ 1976-77

ALLEGHENY—18
Allegheny General Hospital
Allegheny Valley Hospital
Braddock General Hospital
Children's Hospital of Pittsburgh
Forbes Health System of Pittsburgh
Harmarville Rehabilitation Center
Home for Crippled Children
McKeesport Hospital
Montifiore Hospital Association
North Hills Passavent
Ohio Valley General Hospital
Presbyterian University Hospital
South Hills Health System Association
St. Clair Memorial Hospital
St. Francis General Hospital
St. Margret Memorial Hospital
Suburban General Hospital
Western Pennsylvania Hospital

ARMSTRONG—1
Armstrong County Memorial Hospital

BEAVER—1
Medical Center of Beaver County

BERKS—4
Community General Hospital
Reading Hospital
Reading Institute of Rehabilitation
St. Joseph's Hospital

BLAIR—1
Mercy Hospital

BRADFORD—2
Robert Packer
Memorial Hospital

BUCKS—5
Delaware Valley Hospital
Doylestown Hospital
Lower Bucks Hospital
Quakertown Hospital
St. Mary's Hospital

CAMBRIA—4
Conemaugh Valley Memorial Hospital
Lee Hospital
Mercy Hospital of Johnstown
Miners Hospital of North Cambria

CARBON—1
Gnaden Huetten Memorial Hospital

CENTRE—2
Centre Community Hospital (Mountain View)
Center Community Hospital (Willowbank)

CHESTER—4
Bryn Mawr Hospital Rehabilitation Center
Community Memorial Hospital
Paoli Memorial Hospital
Phoenixville Hospital

CLEARFIELD—1
Clearfield Hospital

CLINTON—1
Lock Haven Hospital

COLUMBIA—1
Bloomsburg Hospital

CRAWFORD—1
Spencer Hospital

CUMBERLAND—2
Holy Spirit Hospital
Rehabilitation Hospital for Special Services

DAUPHIN—3
Community General Osteopathic Hospital
Harrisburg Hospital
Milton S. Hershey Medical Center

DELAWARE—5
Crozier-Chester Medical Center
Mercy Catholic Medical Center
Riddle Memorial Hospital
Taylor Hospital
Tri-County Hospital

ERIE—4
Curry Memorial Hospital
Doctors Osteopathic Hospital
Hamot Medical Center
Union City Memorial Hospital

GREENE—1
Greene County Memorial Hospital

INDIANA—1
Indiana Hospital

LACKAWANNA—3
Community Medical Center
Moses Taylor Hospital
Scranton State General Hospital

LANCASTER—4
Elizabethtown Hospital for Children
Ephrata Community Hospital
Lancaster General Hospital
Lancaster Osteopathic Hospital

LAWRENCE—1
Ellwood City Hospital

LEBANON—1
Veterans Administration Hospital

Hospitals reporting cases having ICDA codes 806+ and 958+ 1976-77

LEHIGH—3
Allentown Hospital Association
Sacred Heart Hospital
St. Luke's Hospital

LUZERNE—6
Hazleton State General Hospital
Mercy Hospital
Nesbitt Memorial Hospital
Pittston Hospital
Veterans Administration Hospital
Wilkes-Barre General Hospital

LYCOMING—2
Divine Providence Hospital
Williamsport Hospital

McKean—1
Community Hospital

MERCER—2
Greenville Hospital
Sharon General Hospital

MIFFLIN—1
Lewistown Hospital

MONROE—1
General Hospital of Monroe County

MONTGOMERY—4
Abington Memorial Hospital
Holy Redeemer Hospital
Montgomery Hospital
North Pennsylvania Hospital

MONTOUR—1
Geisinger

NORTHUMBERLAND—2
Shamokin State General Hospital
Sunbury Community Hospital

PHILADELPHIA—20
Albert Einstein, Daroff
Albert Einstein, North
Children's Hospital of Philadelphia
Frankford Hospital
Germantown Dispensary and Hospital
Graduate Hospital of the University of Pennsylvania
Hospital of the University of Pennsylvania
Magee Memorial Hospital Rehabilitation Center
Medical College of Pennsylvania Hospital
Mercy Catholic Medical Center, Misericordia
Moss Rehabilitation Hospital
Nazareth Hospital
Northeastern Hospital of Philadelphia
Pennsylvania Hospital
Philadelphia College of Osteopathic Medicine Hospital
Philadelphia General Hospital
Presbyterian University Medical Center
St. Mary's Hospital
Thomas Jefferson University Hospital
Veterans Administration Hospital

POTTER—1
Charles Cole Memorial Hospital

SCHUYLKILL—3
Ashland State General Hospital
Good Samaritan Hospital
Pottsville Hospital

SOMERSET—2
Somerset Community Hospital
Windber Hospital—Wheeling Community Hospital

SUSQUEHANNA—1
Montrose General Hospital

TIOGA—1
Soldiers and Sailors Hospital

VENANGO—1
Oil City Hospital

WASHINGTON—1
Washington Hospital

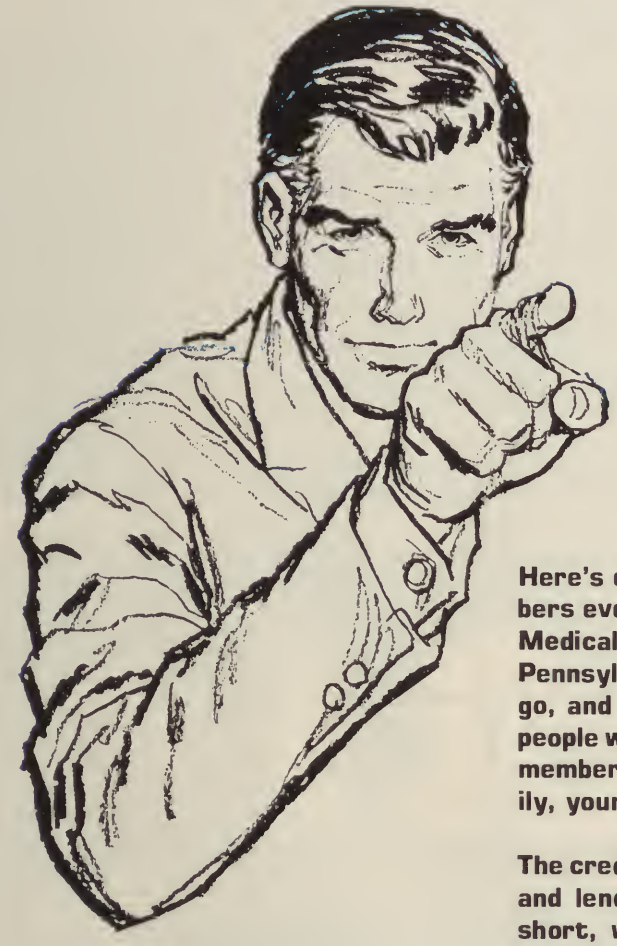
WESTMORELAND—5
Citizens General Hospital
Henry Clas Rick Community Hospital
Jeannette District Memorial Hospital
Monsour Medical Center
Westmoreland Hospital Association

WYOMING—1
Tyler Memorial Hospital

YORK—3
Hanover General Hospital
Memorial Osteopathic Hospital
York Hospital

A total of 134 hospitals reported cases having primary diagnoses with ICDA codes 806+ and 958+

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MDs in the news

An article by **J. Mostyn Davis, M.D.,** of Shamokin, entitled "Little Ways to Save a Lot of Time," has been published in the March 20 issue of *Medical Economics*. In the article, Dr. Davis shares his methods, derived from published management tips and from his own observations, for saving time in the office.

Anita Bahn, M.D., Philadelphia, was appointed recently to the Public Health Committee of the American Medical Women's Association. Dr. Bahn is professor of research medicine and director of epidemiology research and training at the University of Pennsylvania School of Medicine and a senior member of the Fox Chase Institute for Cancer Research.

Three staff physicians at Conemaugh Valley Memorial Hospital, Johnstown, recently were certified in their respective subspecialties. **Mohan S. Mital, M.D.,** and **Rod A. Wall, M.D.,** received certification in cardiovascular disease from the American Board of Internal Medicine and are now diplomates of the American Board of Cardiology. **James E. Richey, M.D.,** is now certified in gastroenterology and is a diplomate of that subspecialty's board.

Robert J. Gibbons, M.D., has been reelected chief of the medical staff at St. Joseph Hospital, Hazleton. Dr. Gibbons is chairman of the grievance committee of the Luzerne County Medical Society, secretary of the Professional Standards Review Organization of Northeastern Pennsylvania, and a charter member of the American Trauma Society.

Michael J. Daly, M.D., Villanova, professor and chairman of obstetrics and gynecology at Temple University Medical Center, has been elected the first president of the newly formed American Society for Psychosomatic Obstetrics and Gynecology. The society's major function is the exchange of information about the way in which emotions affect female reproductive organs and associated symptoms and diseases.

Gerald H. Amsterdam, M.D., assumed the post of chairman of surgery at Jeanes Hospital on February 1, concluding his tenure as president of the medical staff at Albert Einstein Medical Center. Dr. Amsterdam has been an associate clinical professor of surgery at Temple Medical School since 1949, and has done active research in clinical and administrative medical procedures.

Continued



Honored recently for their outstanding contributions to cancer research are (l. to r.) Werner Henle, M.D., and Gertrude Henle, M.D., of the Childrens' Hospital of Philadelphia. Presentation of the award at the American Cancer Society Annual Volunteer Awards Assembly was made by Luther Brady, M.D., chairman of radiation therapy and nuclear medicine at Hahnemann Medical College and Hospital and president of the ACS Philadelphia Division.

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"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma, prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Br.

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***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**

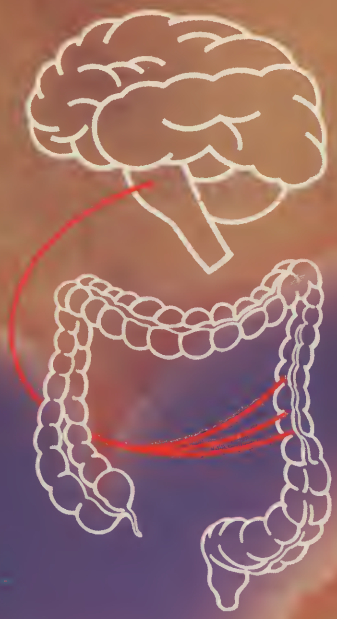
As with all anticholinergics, inhibition of lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction, changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy, constipation Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

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MDs in the news

Continued

David B. Soll, M.D., professor and chairman of ophthalmology at Hahnemann Medical College and Hospital, has been elected president of the American Society of Ophthalmic Plastic and Reconstructive Surgery and the American Association of Cosmetic Surgeons. Dr. Soll is author of *Management of Complications in Eye Plastic Surgery,* a major text in the field.

Bernard A. Eskin, M.D., clinical associate professor of obstetrics/gynecology and psychiatry at the Medical College of Pennsylvania, has been appointed to the executive committee of the prestigious Societé Internationale Senologie. Headquartered in Strasburg, France, the Societé is the international center for the study of breast cancer and related diseases. Dr. Eskin, one of two Americans chosen, will serve on the committee for two years.

Without Randall F. Hipple, M.D., the city of Williamsport might just stand still. Dr. Hipple, Williamsport's foremost physician-politician, has served as vice president of the city council since 1974. A member of the staffs of Williamsport and Divine Providence hospitals, the obstetrician/gynecologist devotes energies to private practice, the presidency of the Board of Health, the Williamsport Recreation Commission, and the Community Arts Council. He is also president of the Lycoming County unit of the American Cancer Society and the clinical coordinator of the ob/gyn and family practice residency programs at Williamsport Hospital. Dr. Hipple's many civic achievements distinguish him as his city's "Doctor of Community Affairs."

The American Academy of Orthopedic Surgery recently certified the following physicians: **Rodger C. Searfoss, M.D.,** Latrobe; **Rolf A. Klein, M.D.,** Franklin; and **David A. Vermeire, M.D.,** Hermitage.

Donald R. Cooper, M.D., Gladwyne, has been elected president of the Philadelphia Academy of Surgery. Dr. Cooper, professor and chairman of the department of surgery at the Medical College of Pennsylvania, is trustee for the First District of the State Society.


Dr. Cooper


Dr. Hendler

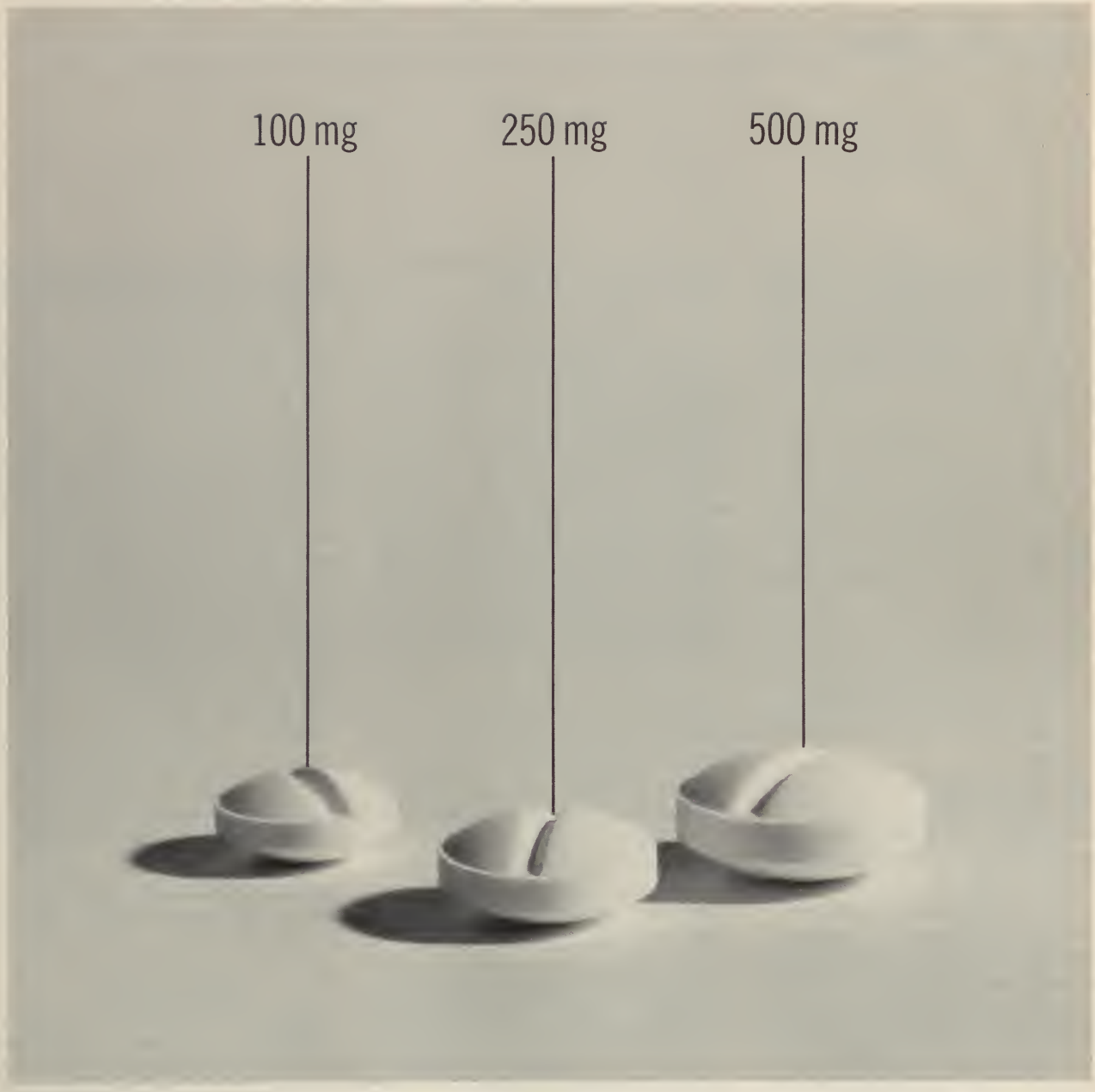
Barry H. Hendler, D.D.S., M.D., has been elected a fellow of the College of Physicians of Philadelphia. Dr. Hendler is director of oral and maxillofacial surgery at the Medical College of Pennsylvania and assistant professor of oral surgery and anesthesia at the University of Pennsylvania School of Dental Medicine.

Louise Jacobson, M.D., of Penn Valley, has been named medical director of the Philadelphia Psychiatric Center's Community Mental Health Programs. Dr. Jacobson is past president of the American Medical Women's Association Branch 25 and the Delaware Chapter of the Medical College of Pennsylvania's Alumnae Association.


Dr. Jacobson


Dr. Kolansky

Harold L. Kolansky, M.D., has been appointed professor of psychiatry and human behavior at Jefferson Medical College, Philadelphia. Dr. Kolansky is director of the division of child psychoanalysis in the Institute of the Philadelphia Association for Psychoanalysis, a past president of the Regional Council of Child Psychiatry, and a delegate to the Assembly of Child Psychiatry Councils.



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Alcoholism in women—the conspiracy of silence

Richard W. Esterly, M.H.S.

Our limited knowledge of the disease of alcoholism is based primarily on findings in male alcoholics. Most treatment models are developed by and for men; many overtly exclude women. Recent findings indicate the following:

- Almost as many women drink as men[1]
- Women often are polyaddicted to alcohol and to other mood altering drugs (minor tranquilizers, barbiturates, etc.)
- Women make up one-third of new members going to A.A.[2]
- Only 28 studies on women alcoholics were done between 1928 and 1970[3]
- Only 14 of 524 programs funded by the National Institute of Alcohol Abuse and Alcoholism are exclusively for women
- Only 30 of 600 halfway houses are exclusively for women

Fortunately, as knowledge about female alcoholics is gained, treatment attitudes change. In ever increasing numbers, females are seeking help.

The greatest barrier for women entering treatment is still attitudinal. Family, friends, employers, and helping professionals are just beginning to cross the judgmental line and to accept the female alcoholic as suffering from a disease of body and emotion that is fatal if not treated. In many areas she is still scorned and rejected. The male spouse is ten times more likely to desert the female alcoholic than a female spouse is to leave a male alcoholic.[4] Those who stay will protect the woman alcoholic.

The female alcoholic, whether a professional, a mother, a housewife, or a worker in the community, shares a conspiracy of silence with those most able to promote treatment. Because of the social and moral stigmas incorrectly attached to female alcoholism, it is vitally important for health professionals to become part of the solution. They must initiate the identification and referral process.

Special concerns

There are a number of special concerns that emphasize the importance of health professionals using their prestige and influence to confront female alcoholism effectively.

Mothers are the primary influence on young children. When alcoholism is present, children are deprived of affection, nurturing, and stimulation. Fifty percent of all alcoholics were raised in families in which at least one parent was alcoholic.[5] The reason for this fact is not known; hereditary and environmental theories can explain it equally. Recent studies of alcoholic parents' twin children who were separated at birth indicate that a susceptibility to alcoholism is inherited. By the time they are 30 years old, children adopted by nonalcoholic families have a rate of alcoholism that is significantly higher than the general population and equal to that of children raised in alcoholic homes.[6]

A second concern with alcoholic women of childbearing age is a condition referred to as fetal alcohol syndrome. Women who drink alcoholicly during pregnancy risk bearing physically and mentally deficient offspring.[7] Manifestations of the condition include cranial-facial, limb, and cardiovascular defects. The original study of 23 offspring of alcoholic mothers found that 17 percent died shortly after birth, 32 percent of the survivors had the syndrome, and 44 percent had IQs of 79 or below at age 7. Recent studies have confirmed these complex findings.[8,9]

The prevalence of polyaddiction among female alcoholics is the third concern. Our society offers "a pill for every problem." This life style is dangerous and can contribute dramatically to the psycho-physical problems of alcoholism. There is such a strong cross-addiction potential with alcohol and tranquilizers that many experts refer to alcoholism as a more generic "sedativism."

A fourth concern is that the female alcoholic is more likely to be labeled "psychiatric" and more likely to be hospitalized for psychiatric diagnosis than is her male counterpart.[10] This may at times explain some female alcoholics receiving mood altering drugs. In our society the label of "psychiatric" is more acceptable for women and "alcoholic" is more acceptable for men.

Lastly, the family of the female alcoholic may be defensive about her drinking habits. They need help to resolve their feelings of guilt, shame, and helplessness. The possibility of alcoholism in the spouse or other close family members also must be explored. One study revealed almost one-third of spouses to be alcoholic.[11]

Identification

Alcoholism is defined by the American Medical Association as "an illness characterized by preoccupation with alcohol and loss of control over its consumption . . . a type of drug dependence that can harm a person's health and interfere with the ability to work and get along with others."[12]

Alcoholism is an illness characterized by denial. It is this denial that makes alcoholism the most untreated disease in this country. The female alcoholic will not report problems with alcohol and other drugs. One study of female alcoholics in the offices of physicians showed that 86 percent were there for reasons other than alcohol problems.[1] The American Hospital Association estimates that between 25 and 30 percent of medical-

Mr. Esterly is executive director of Alcoholism Services, Inc., in Harrisburg.

surgical patients are directly or indirectly admitted because of alcohol.[13]

Identification and diagnosis of female alcoholism is carried out as with other illnesses. There are characteristic sets of presenting problems and symptoms that suggest an exploration of drinking habits.

Physically, the female alcoholic will not appear intoxicated in the office and probably will not accurately report drinking.[14] She may appear nervous or anxious because she feels guilty or because she is not drinking at that time. This in part explains why many women become polyaddicted to tranquilizers. A physician may treat the tranquilizer withdrawal condition instead of recognizing the underlying problem.

The female alcoholic may experience blackouts and seem to be disoriented in regard to dates and responsibilities. She may report fatigue, restlessness, lack of appetite, insomnia, sleepiness, and depression. In the late stages she suffers tremulousness, hallucinations, and in some instances disorientation, confusion, convulsions, and delirium tremens. In these later stages alcoholism is associated with brain damage and disorders of the digestive tract, pancreas, and liver; inflammation of the heart and other muscle tissues; and increased risk of accidents and injury.

A much higher percentage of younger women than women over age 50 are drinking and experiencing problems with alcohol. This progression is telescoped in that women proceed from controlled to uncontrolled drinking in shorter periods of time. Feelings of greater comdemnation and guilt and fears of being outcast contribute to greater concealment and more rapid development.[15]

Psychologically, female alcoholics demonstrate certain characteristics which should be noted. The drinking problems of many female alcoholics seem to result from related life situations(s), particularly when the alcoholism develops later in life. These women have a relatively stable adjustment prior to the specific life situation(s). The prominent symptons of this group are anxiety and depression.

Other alcoholic females drink excessively earlier in life, have problems earlier, and seem to have multiple problems. Because of the earlier onset of problem drinking, normal maturation and interpersonal development are blocked and other maladaptive psychological problems may be present.

Referral

It is important to remember that the suffering of the disease is more tolerable to the patient than is the stigma of being a woman alcoholic. The physician must expect denial, deceit, and defiant behavior; this is the nature of the illness. The same psycho-medical history used for other diseases is the best source for diagnosing alcoholism. If any of the medical or psychological symptoms discussed are present, the physician should further investigate the drinking habits.

To understand the attitudes and emotions of the alcoholic woman, the physician must first work through his own feelings about alcoholism. When the female alcoholic presents herself to a physician, her illness is usually severe. Short-term hospitalizations seldom do more than withdraw the individual from the toxic effects of alcohol.

A life-saving combination that has been put to use in central Pennsylvania joins physicians, a hospital, and a private, state-funded organization that provides comprehensive inpatient and outpatient programs. The female alcoholic receives alcoholism and health education, introduction to Alcoholics Anonymous, group and individual counseling, and professional family treatment that is conducive to a satisfying life without chemicals.

The implications of female alcoholism are far-reaching; the problem is social, psychological, and physicial. Its only solution is the commitment of those involved—the patient, her family, and her physician—to face the problem, to expose the conspiracy of silence, and to seek treatment. □

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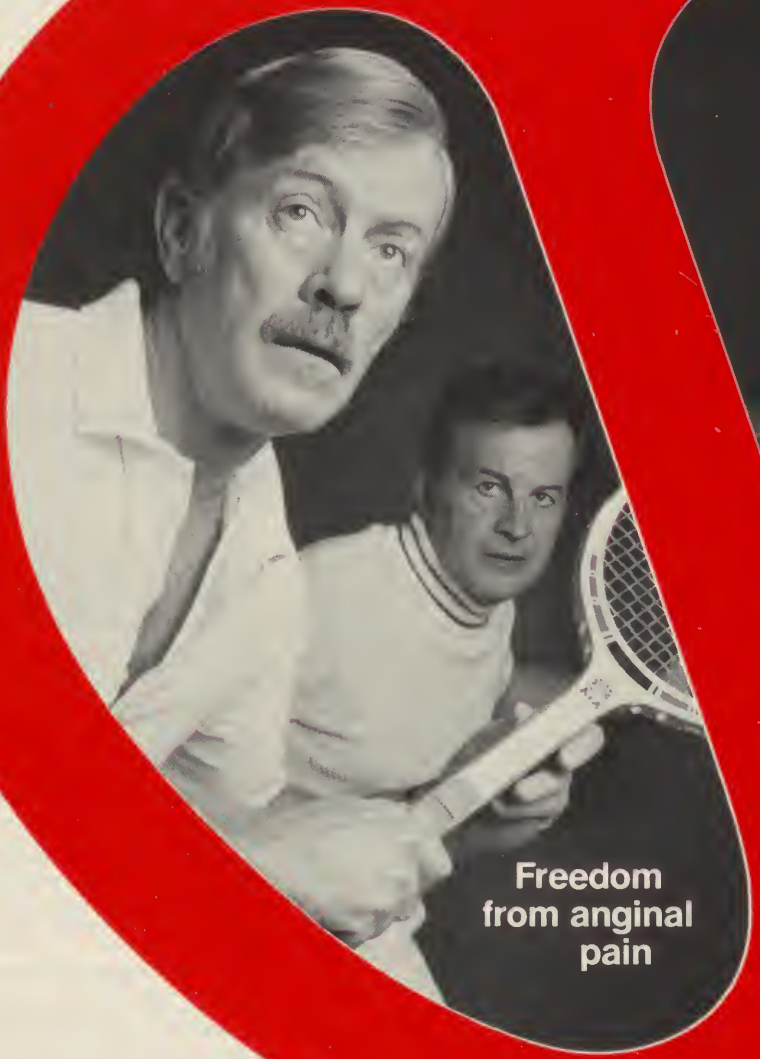
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obituaries

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• **Fred A. Bissel,** Pittsburgh; Hahnemann Medical College, 1935; age 69; died February 7, 1978. He was a cardiologist who had served on the staffs of Shadyside and St. Francis General hospitals.

• **Samuel Goldstein,** Pittsburgh; University of Pittsburgh School of Medicine, 1920; age 82; died February 4, 1978. He had served as chief of Montefiore Hospital's division of obstetrics and gynecology for 29 years. He also served as president of the hospital's staff from 1953 to 1955. He was a life and board member of the American College of Obstetrics and Gynecology.

• **Horace C. Kinzer,** Lancaster; University of Pennsylvania School of Medicine, 1907; age 98; died February 8, 1978. He was a past president of the Lancaster County Medical Society and had served on the staff of Lancaster General Hospital for more than 50 years.

• **Peter G. Motta,** Carnegie; University of Maryland School of Medicine, 1924; age 80; died January 24, 1978. He was honored in 1974 for 50 years of medical service.

• **George J. Schwartz,** Philadelphia; Jefferson Medical College, 1933; age 73; died January 27, 1978. He was a surgeon and former president of the medical staff of Methodist Hospital.

• **Michael V. Sivak,** Erie; Hahnemann Medical College, 1941; age 62; died January 28, 1978. He had been a member of the medical staff at St. Vincent's Health Center for 37 years. Dr. Sivak was president and director of Garde Pharmaceuticals, Inc., and former director of the Studebaker Laboratories.

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Naming and developing an office manager—part one

Leif C. Beck, LL.B., C.P.B.C.
Vasilios J. Kalogredis, J.D.

A general personnel management rule holds that a supervisor is necessary when there are at least three employes and that there should be one supervisor for each seven employes. These ideals apply more or less to smaller medical offices, but applying them woodenly can be as troublesome as not using supervisors at all.

In effect, we consider the designation of an office manager the most critical decision faced by medical practice management. When a good office manager is intelligently guided by the physician, the usual problems of billing systems, collections, third party insurance, scheduling and so on are usually well handled. Without the manager, or with the wrong one, ensuing chaos overshadows all other specific problems.

Who needs a manager?

The need for an office manager and the way in which the position is filled vary from office to office. In one case an excellent employe might be promoted to full-time manager; in another case a new employe could be recruited specifically for the role; and in a surprising number of situations there is no need to create an office manager role.

Our reasons for specific recommendations are often subjective. In some offices a number of senior assistants may work well together, perhaps interchanging duties as the needs arise and considering the office their joint responsibility. To name one of them manager might destroy the good working environment, and to hire someone from outside the group would probably be destructive.

In other situations the personality and/or attitude of the doctors might make it virtually impossible for any lay individual, no matter how capable and devoted, to function adequately as a manager.

What can a manager do for you?

While the designation of a manager is sometimes inappropriate, we are convinced that most medical offices are vastly improved by the presence of an effective office manager. The intelligent delegation of responsibilities to such a person relieves the doctor of problems demanding time and attention. There should be someone within the practice who assures that all systems and employes function well, and who is directly accountable to the physician for that success.

The office manager's primary responsibility is in personnel management. Doctors typically lack the time or temperament to communicate effectively with their staffs, and thus fail to apply a full range of sound personnel principles so useful to medical office effectiveness.

A manager can, however, serve many additional functions in a busy office. He or she can take responsibility for all the business systems, making changes as they become necessary. The manager is far more likely to understand the practice and its intricate workings than is an outside consultant, for example, and thus finding the right person to fill the role will often solve many other problems.

The office manager can and should perform many tasks typically considered doctor-level responsibilities. Contact with the practice's accountant, attorney and pension investment counselors, for instance, can better be accomplished by the manager. The doctor is then free to make decisions based on the manager's "spade-work." Similarly, details of moving an office or opening a second office, negotiating for equipment or furniture purchases, changing telephone or dictation arrangements, and even helping conduct a doctor's hospital committee responsibilities can in large part be accomplished at the manager level.

Doctors are sometimes skeptical that managing a moderate-size office is really a busy job. The thought of someone performing no visible office tasks, except to "manage the office," may tend to annoy the overly busy physician and staff. We subscribe strongly to an adage which so often proves true: The better the office is functioning, the less the manager seems to be doing; the busier the manager, the less effective the office.

Perhaps as some indication of responsibilities an office manager might assume, Table 1 presents a sample job description for the position. Some doctors will protest that it appears insufficient to occupy a person's time. We agree—the position is deceptive. We sometimes find it hard to quantify what will really be done in the job, for the responsibilities are in large part subjective; nevertheless, they are important.

Where do you find one?

We place medical practice managers in three categories: lay administrators, full-time office managers, and so-called "super-aides."

A lay administrator is a person hired specifically to manage a practice even though he or she has not served in various office roles. The administrator has never been a medical secretary, assisted with patients, sat at the reception desk, or filled out a Blue Shield form. He or she simply has experience as a "manager/supervisor," with a capability of applying those skills and personality traits to a medical office just as to a commercial business.

There is a trend in practices of as few as three doctors toward employing a full-time manager from the business field rather than from medical office work. These lay administrators tend usually to be male, a phenomenon of the job market at the executive level and the biases of many doctors. Whether male or female, we see the trend as healthy proof of a practice's need for management responsibility.

The second category of manager is

The authors are the principal consultants of Management Consulting for Professionals, Inc., Bala Cynwyd.

the full-time office manager. This person, usually female, has been promoted from one or several regular medical jobs to manager and no longer performs her old jobs. In our own office, for example, our former secretary is now our full-time manager.

Far more practices should follow our approach of converting the highly capable employe into a manager. Selection of the person must consider intelligence, perceptiveness, loyalty and personality, for one is not a good manager just because she was a good receptionist, bookkeeper, or secretary. When an employe has the desired qualities, her pre-existing relationship with doctors and staff will augment her acquaintance with the practice and will make her an ideal supervisor/executive.

The third category is the all-too-common "super-aide"—the most senior or most conscientious employe who is given the additional title of office manager. She is not relieved of regular duties to have any time for managing.

The practice that names a "super-aide" has taken only a small step toward good office management. So much more can be accomplished when the physician(s) and the aide further build the role toward that of a full-time office manager. If more responsibility is delegated to her and she performs well, the expanded role can evolve without being a shock to either side. Some doctors consider the upward trend a threat, but we see it as a great opportunity.

Whether the office manager is brought up through the ranks or is recruited from outside the office, creation of the position presents a challenge to both the designee and the physician. The new manager will assume responsibilities which she may not be able to handle. Naming a good assistant as manager creates a risk—she will likely be lost as an employe if she fails to manage effectively.

The challenge to the doctor is even greater. It is essentially the physician's responsibility to develop the manager's role and to set the tone for her authority with the staff. If a doctor refuses to entrust the manager with higher level concerns, or if he continues to call on her for menial tasks, a managerial atmosphere will not be created. If the physician undercuts the manager on personnel matters, she will lose the staff's respect and her ability to supervise effectively.

The physician should take real pride in developing an employe into an office manager. Failure to carry out the job effectively is more often the doctor's fault than it is the manager's. Another old adage must be kept firmly in mind: Someone must manage the manager if she will be successful. That someone is, of course, the physician. □

TABLE 1

Sample Job Description for Office Manager

1. **Financial**
   - Prepare proposed annual budget.
   - Approve all expenditures.
   - Prepare or review and analyze monthly statements.
   - All special financial studies, reports, etc., requested by doctors or determined necessary by office manager.
   - Liaison with accountants.
2. **Personnel**
   - Recruit, hire and fire.
   - Supervise, including salary review and proposed adjustments.
   - Maintain control and records of vacations, sick leave, etc.
   - Organize regular office meetings and set agendas.
   - Determine and change personnel assignments and job descriptions as needed.
3. **Supplies**
   - Order all supplies (medical and clerical).
   - Maintain supply records, pricing studies, etc.
4. **Professional Corporation**
   - Monitor fringe benefit programs.
   - Supervise pension and profit sharing funds (as liaison between advisors and doctors).
   - Coordinate with attorney and accountant on corporate details.
5. **Collections**
   - Supervise systems for delinquent account follow-up.
   - Handle difficult collection matters.
6. **Audit Controls**
   - Review and supervise internal systems for handling cash, recording mail receipts, writing checks, etc.
   - Follow-up audit control systems devised by accountants.
7. **Insurance**
   - Handle and recommend all office and corporate insurance coverages.
8. **Office Facilities**
   - Assure proper maintenance of present office; order new equipment; obtain supplies and services.
   - Be responsible for all aspects of office maintenance and coordination with landlord.
   - Investigate and act as agent for doctors in office building ownership, development of plans for office changes, etc.
9. **Personal for Doctors**
   - Act as business agent for doctors personally in all areas in which their time can be saved for medical work.
   - Carry out assignments for doctors as may be required of their civic, medical, or other committee positions.

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*R. B. Greenblatt, M.D.; R. Witherington, M.D.,; I. B. Sipahioglu, M.D.; Hormones for Improved Sexuality in the Male and Female Climacteric. **Drug Therapy,** Sept. 1976.

DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE: Robert B. Greenblatt, M.D.,** and **D. H. Perez, M.D.:** "The Menopausal Syndrome," *Problems of Libido in the Elderly,* pp. 95-101. Medcom Press, N.Y., 1974. **HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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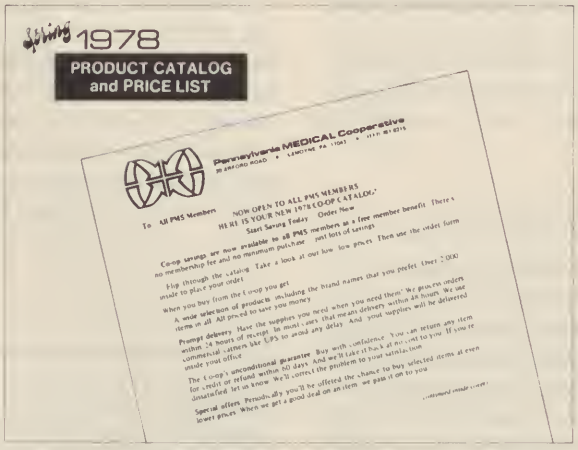
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Physician plays crucial role during adolescence

Frederick J. Humphrey, II, D.O.
Stephen E. Risen, M.D.
Larry L. Ackerman, M.D.

Perhaps no phase of human development is more inherently turbulent than the years of adolescence. The diagnostic challenge of adolescence lies in determining whether a young person's disturbing behavior is part of the active rebellion that is normal during this period or whether it represents psychopathology that requires intervention.

Since the primary care physician has usually established a relationship with the family and child before the child enters adolescence, he can often talk candidly with the adolescent and counsel him and his family about problems typically presented during this time. This relationship with the child enables the primary care physician to determine when acting-out behavior is no longer a matter of normal adolescent turmoil but rather a symptom of psychopathological conflicts.

In treating the adolescent's physical problems, the physician should understand and be sensitive to the patient's psychological state. This article reviews the stages of development within adolescence in order to highlight areas of particular importance to the primary care physician, and discusses the symptoms of psychopathological disturbances during adolescence and the criteria for differential diagnosis.

The adolescent years

Adolescence is brought about by a biologic process that begins with puberty. This means that 15 or 16 year olds who have not yet entered puberty are not considered adolescents, even though they are teenagers. Pubescence and the appearance of secondary sex characteristics cause profound physical and emotional changes in the individual. The adolescent's body image is changing rapidly, the sensitivity of the genitals is altered, and there are biologic urges that create tension not previously experienced.

The adolescent is faced with a tremendous dilemma. When he enters this phase he is very close to his family, and it is with reluctance that he begins the process of separating from them and becoming independent. The parents are also in conflict since they recognize their growing child's need for greater independence, but at the same time wish to keep him close to them.

The conflict between the desire to remain dependent and the urge for independence results in the upheavals that are so common during this phase. The adolescent often fights and rebels even when the family is healthy and supportive because the conflict helps him to avoid the longing to stay protected within the family.

It is much easier for him to separate from the family if the situation is considered to be intolerable and the parents are perceived as adversaries. In pathological family situations, the adolescent's belligerence is easier to understand, and in these circumstances is also a healthy reaction.

Over a period of approximately five years, between the ages of 13 and 18, the adolescent is required to make major decisions that will affect the course of his life. He must select an occupation and establish a sexual and personal identity as an independent, autonomous individual. In contrast to those cultures that choose a young person's occupation and mate, our culture allows the adolescent a wide range of choices.

This freedom gives adolescents an opportunity to match their interests with their choices, but it also leads to confusion and the potential for psychiatric disturbance—suicide is the second most common cause of death among adolescents. Occupational choice in western society determines a person's lifestyle and standard of living, and thus can be seen as crucial in closing off the adolescent process. To choose an occupation means to consolidate one's sense of self and one's identity.

Because the method of preparing for occupations is education and because prolonged education is a requirement for entrance into the professions, the course of adolescence can be greatly extended by education. Thus the age at which adolescence is concluded varies greatly.

The physician may be asked to see the adolescent by parents who are concerned about their child's behavior or some aspect of his performance. In evaluating adolescents it is important not only to assess the presenting problem, but also to determine whether there is any interruption in the developmental process. The primary care physician should therefore have a general understanding of the four sub-phases of adolescence in order to facilitate the process of differential diagnosis.

Pre-adolescence—Pre-adolescence (ages 10 to 13) begins with the initial changes associated with pubescence. There is a period of rapid growth in height and weight, with considerable variation in the onset of this growth spurt. Girls usually mature about two years earlier than boys do, with the median age of pubescence for girls being twelve and a half.

The child becomes quite inattentive

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and restless during this period. He is aware that many things are rapidly changing, including his physical appearance, and that this is a process over which he has essentially no control.

Anxiety caused by changes in body image and heightened awareness of genital sensations frequently results in regression. There is often an increase in masturbatory activity. Parents frequently note that the child is much more giddy or demanding, and that his mood is more labile. Although mood changes are partially due to increasing sexual tension, they can also be understood if one compares the process of relinquishing childish dependence upon the parents to the process of mourning.

Typically, the child attempts to use defense mechanisms that have been successful in the past. If the child had previously been quite compulsive, for example, this behavior might be accentuated.

In response to growing sexual awareness there is a tendency, particularly among boys, to avoid members of the opposite sex. This is a time when there is an increased interest in secret clubs and groups that exclude the opposite sex.

Early adolescence—With the onset of early adolescence (years 13 and 14), the child's restlessness and sense of irritability with family members increases. There is a tendency to be more rebellious and unaccepting of parental dictates. The importance of family relationships and family values diminishes and the peer group becomes more important as the adolescent separates from the family.

During this period the adolescent is still very much a family member, but he focuses on close relationships with other children. Intense "crushes" may develop that involve friends or older persons of the same or opposite sex.

It is important to keep in mind that developmentally the adolescent has maintained a close and loving relationship with both a male and a female parent. The child is now transferring these close attachments and identifications with family members to individuals within his peer group. Consequently there are intense relationships with members of both sexes that involve sharing secrets and camaraderie.

Mid-adolescence—During this period (years 15 and 16), adolescents more firmly establish their psychological separation from the family; the peer group becomes the primary object of their attention. In childhood the parents helped the individual solve interpersonal problems and determine what was proper and correct, but during adolescence these functions are transferred to the peer group. If the peer group says that it is important to wear one's hair long, then that value becomes imperative to the adolescent, regardless of what the parents consider appropriate.

As the adolescent moves away from the family emotionally, there is an increase in his egocentricity. He is often filled with a false sense of power and omnipotence that can become dangerous, for it may lead to taking risks and exercising poor judgment. This is frequently combined with a sense of isolation and depression as he loosens his family ties.

There is also an intense craving for stimuli. Adolescents physiologically have an enhanced ability to appreciate and perceive color and sound, which contributes in part to their liking for bright colors and loud music. Immersion in loud music is also a diversion from the internal turmoil that exists. Mid-adolescents often have periods of tremendous creativity; they may become quite skilled in writing poetry or engrossed in keeping a diary.

Dating usually begins during mid-adolescence. Heterosexuality becomes more established, and there is less need to be with friends of the same sex. A capacity for being empathic and truly loving toward another person is developed to replace the earlier tendency for self gratification.

Prominent defenses during mid-adolescence are intellectualization, asceticism, and uniformism. Through intellectualization, adolescents are better able to cope with conflictual matters such as their emerging sexual behaviors. This tendency to intellectualize accounts for the adolescent spending hours discussing issues with close friends. The use of the telephone allows adolescents to continue their intellectual discussions and to maintain their important peer group contacts even when they are at home with the family.

In asceticism, there is an attempt to give up all forms of pleasure in order to control wishes and fantasies that the adolescent finds distressing, particularly sexual fantasies. Asceticism accounts for some of the eating fads seen in adolescence; there may be periods of dieting alternating with loss of control during which the adolescent eats foods that he has decided are not good for him.

Uniformism is an attempt by the adolescent to be exactly like his peers in every way. Through conformity, the adolescent attempts to diminish some of the anxiety associated with having to make choices on his own. By imitating his peers, he does not have to struggle with deciding what constitutes appropriate behavior.

Late adolescence—It is during late adolescence (years 17 and 18) that there is a consolidation of the personality. The tendency to be negative and rebellious fades as the adolescent becomes more genuinely independent and self reliant. The exact age at which late adolescence is concluded varies in that individuals in their early twenties who are still involved in higher education may continue to demonstrate characteristics of mid- and late adolescence.

Adolescence ends with the completion of the various tasks previously discussed. During this final phase, the adolescent reestablishes meaningful relationships with the family on a more mature level and usually begins to reaccept the values of the family as his own.

Providing medical care

Physical examinations provoke a great deal of anxiety in adolescents; they are often afraid that genital examination will disclose evidence of masturbation or that they will have an erection during examinations. Examination of the genitals and rectum should not be done unless specifically indicated. If an examination is needed for medical reasons, the physician should discuss the reasons for the examination with the patient and explain exactly what he will do before the adolescent is asked to disrobe.

The regression caused by the anxiety of adolescence frequently appears as an upsurge of oral cravings that contribute to the adolescent's preoccupation with food. The significance of this orality is obvious in that it is one way the adolescent can indulge in forbidden activities; adolescents tend to desire those foods that are not approved by their parents. Adolescents who use the defense of asceticism may diet inappropriately or restrict their intake to foods that do not provide adequate nutrition. When this is noted, it is important that the physician inform the adolescent of the possible consequences of his behavior.

Another important consequence of intensified orality is the adolescent's susceptibility to drug abuse. The physician should avoid prescribing unnecessary medications for adolescents and closely monitor those medications that are prescribed. The physician also must be alert to signs of drug abuse in order to allow for prompt intervention.

As a result of the endocrinologic changes associated with puberty, most adolescents are troubled by acne. Even a mild case of acne may be devastating to the adolescent, who is sensitive to his appearance. The physician's attention to his patient's concerns about acne and his counsel on how to deal with the problem, including periodic visits to monitor progress, may be extremely helpful in developing good rapport with the adolescent. Periodic visits also provide an opportunity to observe the adolescent for other signs of difficulty and allow for discussions concerning the patient's relationships with parents and peers.

Confidentiality is of great concern to the adolescent. Whereas physical examinations during childhood were usually followed by a discussion with the parents about their observations of the patient, the physician should communicate directly with the adolescent and give him as much responsibility as possible in his own care. Whenever possible, the physician should obtain the patient's agreement in discussing his medical condition with the parents. It is important, however, not to promise the adolescent absolute confidentiality since the physician might learn something, such as pressing suicidal ideation, that would force him to contact the family.

Detecting psychopathology

Adolescent behavior should be viewed in the context of what is expected for the age. For example, if a 17- or 18-year-old adolescent has never dated or participated in social activities outside of the home and is overly attached to the family, he is clearly not progressing developmentally. Thus further evaluation and possible treatment is indicated even though the adolescent may not present any behavior problems.

In addition to the failure to progress developmentally, there are three types of behavior or symptom clusters that may indicate psychopathology. The first set of symptoms, which indicates an underlying psychotic process, includes evidence of delusional thinking, auditory or visual hallucinations often associated with bizarre behavior, and/or a tendency to withdraw from peers and family. The symptomatic profile of schizophrenia beginning in adolescence is similar to that of adults and does not usually present a diagnostic dilemma.

The main differential diagnosis is between a functional psychosis and a psychosis associated with drug abuse. Patients who are using psychotomimetic or hallucinogenic drugs generally demonstrate an organic brain syndrome: they are often disoriented, and there is a predominance of visual rather than auditory hallucinations. In evaluating all adolescents it is essential to obtain a thorough drug history, for drug abuse is part of the differential diagnosis of all behavior disorders in adolescence.

The symptom cluster associated with depression is similar to that seen in adults. There may be withdrawal, psychomotor retardation, fatigue, apathy, inability to sleep or oversleeping, loss of appetite or overeating. With adolescents, it is most important to evaluate for suicidal ideation because this is a serious and common problem in depressed adolescents.

The symptom cluster that is most difficult to diagnose differentially is aggressive acting-out behavior within the family, for such behavior may be normal during adolescence. When evaluating the adolescent's level of functioning, the physician carefully assesses the quality of the adolescent's peer relationships as well as school performance, attendance, and attitude because these are often more accurate indicators of the adolescent's functioning than is his relationship within the family.

Developmentally, tension within the family can be anticipated because the adolescent is involved in the painful process of psychologically disengaging from the family unit. Adolescents with significant acting-out behavior who are also having difficulty in establishing and maintaining meaningful peer relationships are in need of further evaluation and treatment. In addition, it should be kept in mind that acting out can be the result of underlying depression.

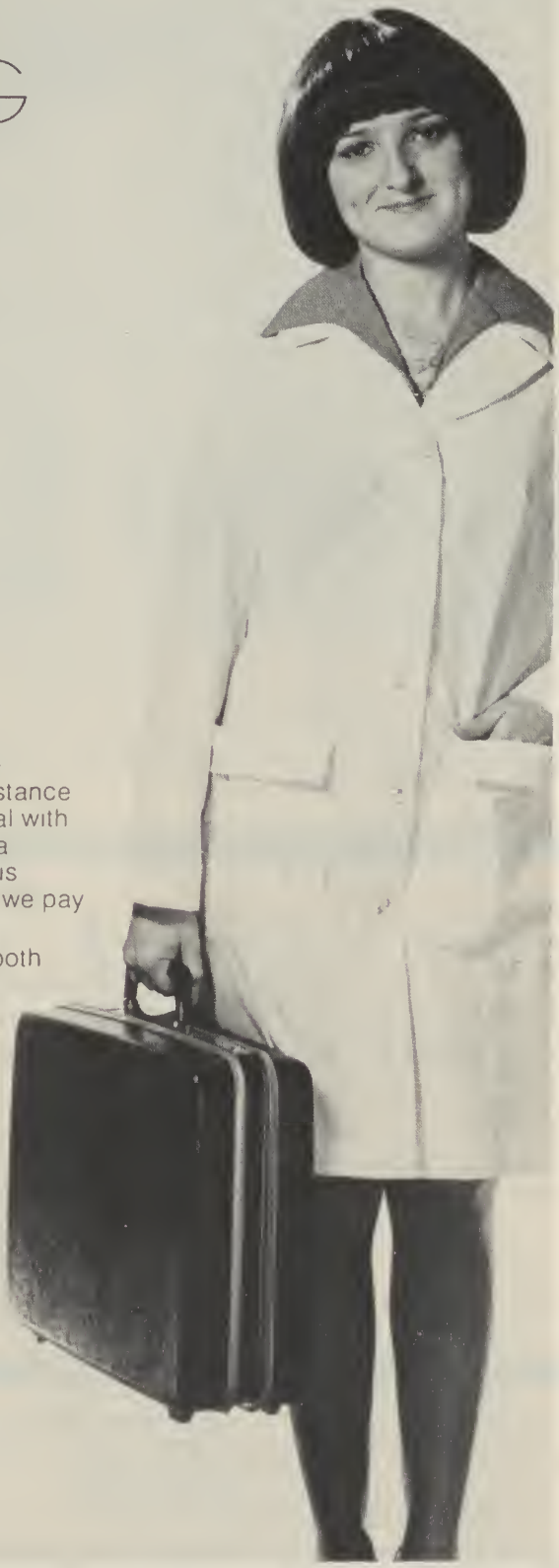
Certain types of behavior may require intervention even though they may not be associated with a significant degree of psychopathology. For instance, adolescents with satisfactory peer relationships may be involved with a peer group that engages in delinquent social behaviors that might bring the adolescent into conflict with the police. Such behavior clearly requires attention even though it might not require psychiatric treatment.

The primary care physician should develop a solid rapport with his young patients prior to the onset of adolescence. Once children are old enough to understand, the physician may stress that he is their doctor as well as their parents' doctor, and may talk with them directly about their physical problems. The establishment of a positive relationship with the adolescent enables the physician to serve as an effective counselor who is in a unique position to identify early signs of difficulty in both the child and the family. □

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Full-time Physician—To serve as medical director for division of large company in Philadelphia area. Salary negotiable. Submit CV to Department 782, PENNSYLVANIA MEDICINE, 20 Erford Rd., Lemoyne, PA 17043.

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Medical Director—Wanted by Pennsylvania HMO. Please send resume to Physicians Medical Center, East First and Spruce Streets, Birdsboro, PA 19508, % Medical Director.

POSITIONS WANTED

If You Need—A partner or associate; a physician to continue your practice upon your retirement; or a specialty physician for your hospital staff, contact PMS Physician Placement Service, Donna F. Wenger, Assistant Director Educational Activities, Pennsylvania Medical Society, 20 Erford Rd., Lemoyne, PA 17043; (717) 763-7151.

Certified Physician's Assistant—B.M.S.C. Desires position with medical center or rural physician providing primary care in Pennsylvania. For resume write or call Robert Pyle, 1028 Mell Ave., Clarkston, GA 30021; (404) 292-0494.

Internist—Well qualified, board certified, available for part-time employment in Philadelphia area. Write Box A-12, 919 Friendship, Philadelphia, PA 19111.

Physician's Assistant—Graduates of the Rutgers University Program will be available for employment on June 1, 1978. Inquiries or requests for resumes may be addressed to: College of Medicine & Dentistry of New Jersey, School of Allied Health Professions, P.A. Program, Box 101, Piscataway, NJ 08854; (201) 564-4444.

Internist—29, ABIM, American born, American trained, desires to join group in eastern or southcentral Pennsylvania. Write Department 780, PENNSYLVANIA MEDICINE, 20 Erford Rd., Lemoyne, PA 17043.

Physician Assistant—Seeks employment in eastern Pennsylvania in Family Practice. Other specialties considered. Please send inquiries to K. Tomczyk, 619 Carsonia Ave., Reading, PA 19606.

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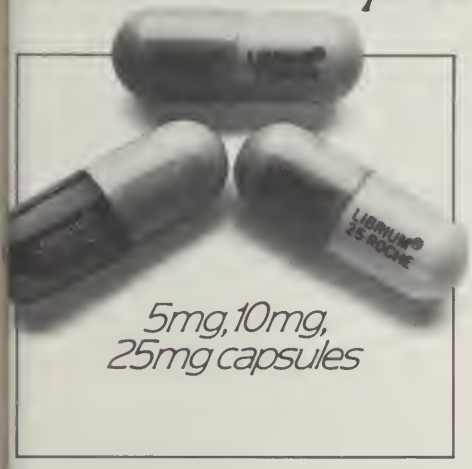
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5mg, 10mg, 25mg capsules

- ☐ Proven antianxiety performance
- ☐ An unsurpassed safety record
- ☐ Predictable patient response
- ☐ Minimal effect on mental acuity at recommended doses
- ☐ Minimal interference with many primary medications, such as antacids, anticholinergics, diuretics, cardiac glycosides and antihypertensive agents

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states. Efficacy beyond four months not established by systematic clinical studies. Periodic reassessment of therapy recommended.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Warn patients that mental and/or physical abilities required for tasks such as driving or operating machinery may be impaired, as may be mental alertness in children, and that concomitant use with alcohol or CNS depressants may have an additive effect. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. Oral—Adults: Mild and moderate anxiety and tension, 5 or 10 mg t.i.d. or q.i.d.; severe states, 20 or 25 mg t.i.d. or q.i.d. Geriatric patients: 5 mg b.i.d. to q.i.d. (See Precautions.)

Supplied: Librium® (chlordiazepoxide HCl) Capsules, 5 mg, 10 mg and 25 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available singly and in trays of 10. Libritabs® (chlordiazepoxide) Tablets, 5 mg, 10 mg and 25 mg—bottles of 100 and 500. With respect to clinical activity, capsules and tablets are indistinguishable.

synonymous with relief of anxiety

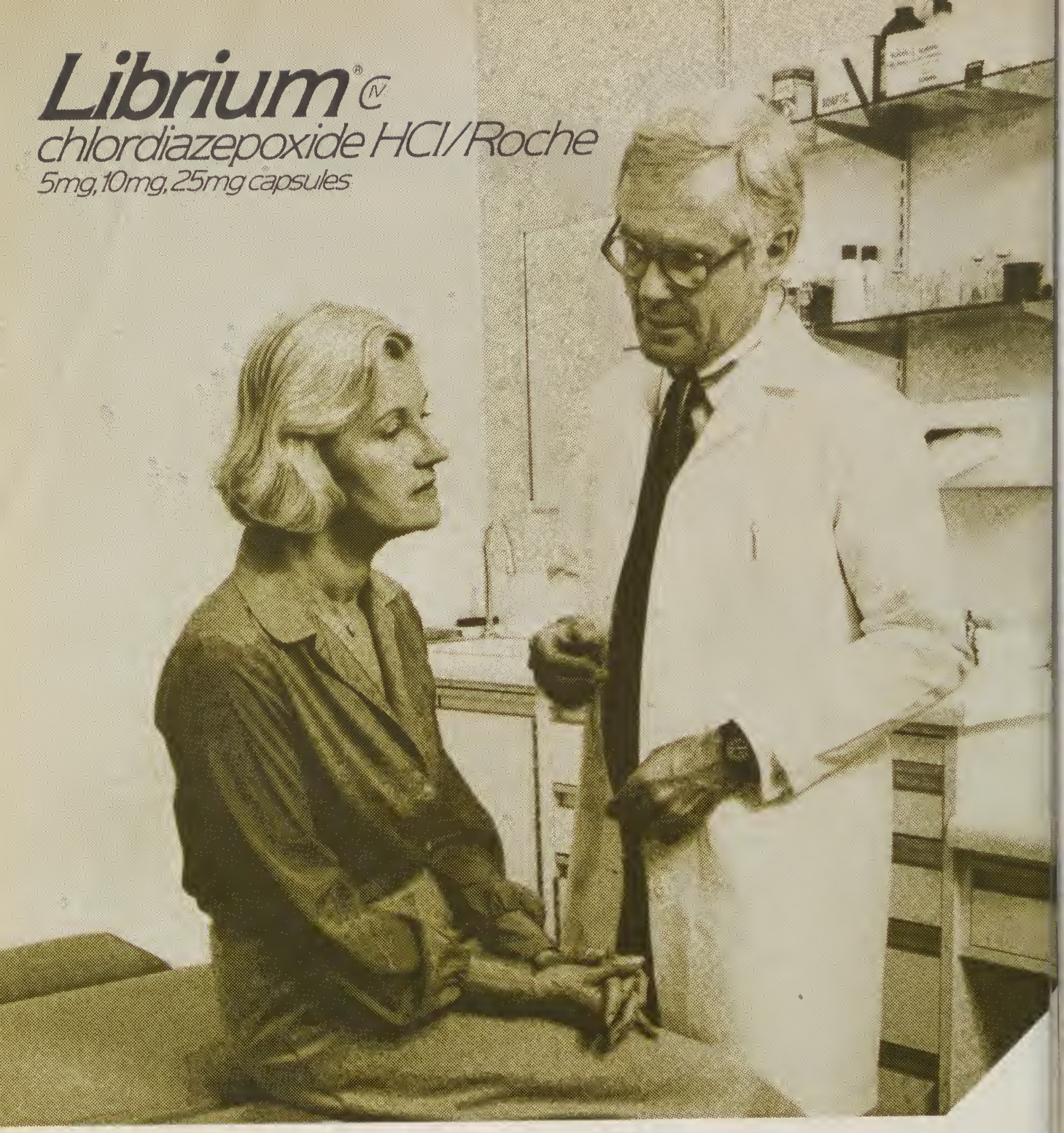
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Manati, Puerto Rico 00701

Please see following page.

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chlordiazepoxide HCl/Roche

5mg, 10mg, 25mg capsules



synonymous with relief of anxiety

ROCHE

Please see preceding page for a summary of product information.

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Pennsylvania Medicine

Vol. 81, No. 6 JUNE 1978



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When cystitis recurs... **Bactrim fights uropathogens**



at 3 important sites

the Bactrim three-system counterattack...

① urinary tract

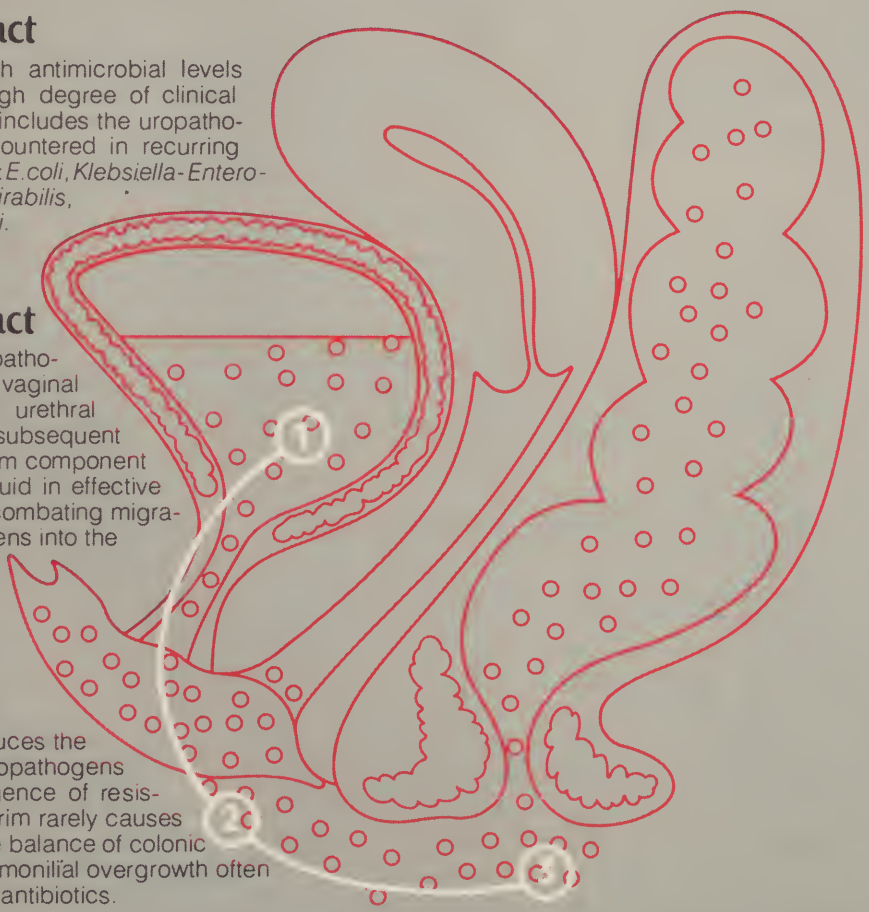
Bactrim provides high antimicrobial levels in the urine and a high degree of clinical efficacy. Its spectrum includes the uropathogens most often encountered in recurring urinary tract infections: *E.coli*, *Klebsiella-Enterobacter* and *Proteus mirabilis*, *vulgaris* and *morganii*.

② vaginal tract

Bactrim combats uropathogens colonizing the vaginal introitus, a source of urethral contamination and subsequent cystitis. Its trimethoprim component diffuses into vaginal fluid in effective concentrations, thus combating migration of urinary pathogens into the urinary system.

③ lower intestinal tract

Bactrim markedly reduces the colonic reservoir of uropathogens with negligible emergence of resistance. Moreover, Bactrim rarely causes adverse effects on the balance of colonic flora...seldom causes monilial overgrowth often associated with many antibiotics.



to clear her infection and combat reinfecting organisms

BACTRIM™ DS DOUBLE STRENGTH TABLETS

(160 mg trimethoprim and 800 mg sulfamethoxazole)

JUST ONE TABLET B.I.D. FOR 10 TO 14 DAYS

ROCHE

Please see summary of product information on next page.



When cystitis recurs...

BACTRIM™ DS DOUBLE STRENGTH TABLETS

(160 mg trimethoprim and 800 mg sulfamethoxazole)

fights uropathogens at 3 important sites

- ☐ Highly effective against most urinary invaders
- ☐ Indicated even in presence of structural abnormalities and vesicoureteral reflux (so clinically significant in children)
- ☐ Indicated in patients as young as two months of age
- ☐ Dual action minimizes microbial resistance
- ☐ Generally well tolerated, with or without food
- ☐ Easy-to-follow b.i.d. dosage schedule
- ☐ During therapy, maintain adequate fluid intake; perform frequent CBC's and urinalyses with microscopic examination
- ☐ Contraindicated during pregnancy and the nursing period, in patients hypersensitive to its components and in infants under 2 months of age

ROCHE
Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Before prescribing, please consult complete product information, a summary of which follows:

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli, Klebsiella-Enterobacter, Proteus mirabilis, Proteus vulgaris, Proteus morganii.* **It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination.** *Note:* The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

Also for the treatment of documented *Pneumocystis carinii* pneumonitis. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.

The recommended quantitative disc susceptibility method (*Federal Register*, 37:20527-20529, 1972) may be used to estimate bacterial susceptibility to Bactrim. A laboratory report of "Susceptible to trimethoprim-sulfamethoxazole" indicates an infection likely to respond to Bactrim therapy. If infection is confined to the urine, "Intermediate susceptibility" also indicates a likely response. "Resistant" indicates that response is unlikely.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides, pregnancy; nursing mothers; infants less than two months of age.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias.* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions.* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

Urinary tract infections. Usual adult dosage—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days. Recommended dosage for children—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. A guide follows *Children two months of age or older:*

Weight		Dose—every 12 hours	
lbs	kgs	Teaspoonfuls	Tablets
20	9	1 teasp. (5 ml)	½ tablet
40	18	2 teasp. (10 ml)	1 tablet
60	27	3 teasp. (15 ml)	1½ tablets
80	36	4 teasp. (20 ml)	2 tablets or 1 DS tablet

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	½ the usual regimen
Below 15	Use not recommended

Pneumocystis carinii pneumonitis: Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: *Double Strength (DS) tablets,* each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100; Prescription Paks of 20. *Tablets,* each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40, available singly and in trays of 10. *Oral suspension,* containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole, fruit-licorice flavored—bottles of 16 oz (1 pint).

TWO COUNCILS DIVIDE SOCIOECONOMIC ISSUES

The Board of Trustees on May 17 approved the formation of a new administrative council in the socioeconomic area. This fifth council, designated the Council on Health Planning and Facilities, will be accountable for services to hospital medical staffs, long term care, health planning (HSAs), and health care costs. Up to now these areas came under the purview of the Council on Medical Service, which still has responsibility for professional liability insurance, relations with third party payers, the state's medical assistance program, and the Pennsylvania medical care program (peer review committees).

FURTHER COUNCIL CHANGES RECEIVE BOARD APPROVAL

The Board approved several additional recommendations changing the accountabilities of councils. The Commission on Health Planning will function under the new Council on Health Planning and Facilities. All insurance benefits programs for members with the exception of professional liability insurance will be administered under the Council on Member Services (formerly Professional Relations and Services). Other councils also are renamed: the Council on Governmental Relations is now the Council on Legislation, and the Council on Medical Service is now the Council on Medical Economics. The Council on Education and Science remains the same.

TWELVE PMS LEADERS AT COST CONTROL MEETING

Twelve representatives of the State Society were among the 70 invited participants at the Health Care Cost Containment Conference held at the University of Pennsylvania June 1 and 2. The conference, sponsored by PMS, the Hospital Association of Pennsylvania, and the Pennsylvania Osteopathic Medical Association, drew representatives of business and organized labor along with health care professionals.

George A. Rowland, M.D., chairman of the PMS Board of Trustees, and the following physicians formed the Society's delegation: Drs. John V. Blady, David W. Clare, Henry H. Fetterman, Raymond C. Grandon, Paul F. Kase, George R. Fisher, III, William Y. Rial, Sidney O. Krasnoff, Joseph V. Caliguiri, Joseph N. Demko, and Webb S. Hersperger.

PMS BOARD APPROVES BUDGET STATEMENT

A consensus statement from the Alliance for June Budget Action was approved by the PMS Board May 17. The Alliance was formed several years ago because in 10 of the last 15 years, Pennsylvania has been without a budget when the new fiscal year began. The Alliance for June Budget Action is composed of over 20 statewide organizations. It calls for reforms in the Commonwealth's budgeting processes in the statement, which will be presented to gubernatorial and legislative candidates.

IMPAIRED PHYSICIAN COMMITTEE FORMED

A Committee on the Impaired Physician, a special committee of the Board to be composed of no more than five members, was authorized by the Board of Trustees on May 17. The committee will implement the Society's program for impaired physicians as adopted by the Board in March 1977.

HEALTH DEPARTMENT TACKLES IMMUNIZATION

Secretary of Health Leonard Bachman, M.D., has announced a two-pronged effort to assure that Pennsylvania's school age children are adequately immunized. First, the department has proposed revised regulations for the immunization law. They will require positive proof of immunization before children can be enrolled in school.

Second, in a joint endeavor, the Departments of Health and Education have asked each school district to review the immunization status of each student and identify by name all students who lack proper protection from diphtheria, tetanus, pertussis, polio, measles, mumps, or rubella. Primarily this project involves auditing school records, but it also involves asking parents, particularly of older students, to complete questionnaires regarding the immunization history of their children.

All students who are identified in the audit as being inadequately protected will be immunized during the next school year either through referral to physicians or school clinics. The Health Department views this as a "catch up" procedure that should improve immunity levels to over 90 percent.

HOSPITAL ASSOCIATION WINS STAY ON RULES

Commonwealth Court Judge Roy Wilkinson on May 15 issued a preliminary injunction against part of the rules and regulations for hospitals scheduled to become effective June 10. The action came as a result of a suit brought by the Hospital Association of Pennsylvania. Twenty sections are partially enjoined and 168 sections are fully enjoined. The remaining 323 sections are enforceable June 10. The old rules will remain in effect in those areas in which the proposed rules are enjoined. Commonwealth Court will hear the suit for a permanent injunction in the fall.

PENNSYLVANIA DELEGATION PLANS FOR AMA MEETING

Pennsylvania delegates to the AMA meeting in St. Louis June 18-21 have a busy week in store. William Y. Rial, M.D., of Swarthmore, is seeking re-election as speaker of the AMA House of Delegates, and George A. Rowland, M.D., of Millville, is a candidate for the AMA Board of Trustees. Pennsylvanians on convention committees are: R. Robert Tyson, M.D., Philadelphia, a member of Reference Committee A (Insurance and Medical Service); Henry H. Fetterman, M.D., Allentown, a member of Reference Committee E (Scientific-Public Health); and Raymond C. Grandon, M.D., Harrisburg, chairman of the Committee on Rules of Order and Business.

MEDICAL ASSISTANCE IMPROVEMENT SOUGHT

The PMS Board of Trustees on May 17 established an ad hoc committee to conduct an analysis of the Medical Assistance Program of the Department of Public Welfare and develop recommendations for its improvement. The undertaking, named "Medical Assistance Program Improvement Project" (MAPIP), will require establishing a data base and seeking guidance and information from other organizations, such as the Hospital Association of Pennsylvania and welfare rights organizations. The ad hoc project committee will be composed of five members designated by the Council on Medical Economics, one by the Council on Legislation, two by the Pennsylvania Medical Care Foundation, and one each by the Keystone Medical Society and the Pennsylvania Osteopathic Medical Association.

Pennsylvania Medicine

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JUNE 1978 Volume 81, Number 6

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Insurance company board expansion voted

The Pennsylvania Medical Society Board of Trustees has appointed three new members to the board of directors of the Pennsylvania Medical Society Liability Insurance Company for terms beginning in April. The new directors are William F. Bouzarth, M.D., Philadelphia; Brooke Roberts, M.D., Philadelphia; and John H. Hobart, M.D., Easton.

Officers reappointed to the insurance company's board for the 1978-79 term are: David S. Masland, M.D., Carlisle, president and chairman of the board of directors; John J. Danyo, M.D., York, vice president; John F. Rineman, Lemoyne, treasurer; and Henry H. Fetterman, M.D., Allentown, secretary.

Also reappointed to the board are: A. Reynolds Crane, M.D., Philadelphia; Donald E. Harrop, M.D., Phoenixville; William J. Kelly, M.D., Pittsburgh; Robert L. Lasher, M.D., Erie; John B. Lovette, M.D., Johnstown; Matthew Marshall, M.D., Pittsburgh; and George A. Rowland, M.D., Millville.

Surgeons meet in fall

The 64th annual Clinical Congress, the world's largest convention of surgeons, sponsored by the American College of Surgeons, will be held in San Francisco October 16-20, 1978. The College anticipates registration of 12,000 physicians for the Congress.

William A. Altemeier, M.D., F.A.C.S., of Cincinnati, Ohio will be installed 59th president of the ACS at the meeting. The program also will include: 18 postgraduate courses on a wide range of subjects; more than 50 panel discussions and symposia on general and specialized surgery; addresses by guest lecturers, including Martin Memorial Lecturer John Lister, M.A., M.D., F.R.C.P., dean of the British Postgraduate Medical Federation; presentation of the College's Distinguished Service Award; and awarding of fellowship to more than 1,500 surgeons in convocation ceremonies on Thursday, October 19.

Registration at the Congress is free for fellows whose dues are paid to December 1977, initiates, and participants in the candidate group. Non-fellows pay $160, non-fellows in federal service pay $125, and surgical residents pay $80.

State Medical Board hearing examiners named

Seven Pennsylvania attorneys have been selected as hearing examiners for the State Board of Medical Education and Licensure, thus allowing Board members to devote more time to matters of policy.

Beginning in May, disciplinary cases brought against physicians licensed by the Board may be heard by a hearing examiner rather than exclusively by board members, as has been the case. Defendants have the right to appeal an examiner's decision to the Medical Board, which reserves the right to conduct a hearing.

The hearing examiners contracted are: Joy Conti and Richard T. Wentley, of Pittsburgh; Isadore Kranzel and James H. Rowland, of Harrisburg; and Daniel Segal, Garnita Selby, and Louis E. Seltzer, of Philadelphia.

State allergists meet

The Pennsylvania Allergy Association will hold its annual spring meeting June 16-18, 1978 at the Toftrees Country Club and Lodge, State College.

New officers of the PAA are D. Lee Miller, M.D., of Pittsburgh, president; George Green, M.D., of Abington, president elect; Pat Nell, M.D., of Philadelphia, secretary; and Charles Blumstein, M.D., of Jenkintown, treasurer.

The Pennsylvania Medical Society has a new telephone number (717) 763-7151 Please correct your records.

Blue Shield reports increase in reserves

Enrollment in Pennsylvania Blue Shield's private programs increased 7,000 in 1977 for a total at year's end of 6,497,000 subscribers, according to the PBS 1977 Annual Report. In addition, 2.78 million persons were eligible for benefits under government programs administered by PBS.

Reserves as of December 31, 1978 were $64.9 million, or 13.4 percent of annual subscription income, compared with $12.5 million, or 3 percent, the previous year. The improved level of reserves was attributed to the continuing concern of participating physicians, favorable trends in the use of benefits, and reduced operating expenses.

More than 21,100 doctors, the highest total ever, had agreements with PBS at year's end. This figure represents a 3.2 percent increase over the 1976 total of 20,487.

Officers' Conference 1978

Society activities, health legislation highlighted

Nancy E. Perkin
Editorial Assistant

Officers' Conference 1978, held April 12 and 13 in Hershey, provided the 267 county medical society officers attending with an intensive, 24-hour program examining a variety of State Society activities, with special emphasis on the relationship between government and medicine.

J. Mostyn Davis, M.D., of Shamokin, was chairman of the committee which formulated the program. Serving with him were Drs. George R. Fisher, of Philadelphia; Paul F. Kase, of Harrisburg; David L. Miller, of New Bethlehem; John P. Mraz, of Erie; Joseph M. Stowell, representative of the Board of Trustees, of Altoona; and John V. Blady, Society president, of Villanova.



Board Chairman George Rowland, M.D., and Society President John Blady, M.D., were joined by John Rineman, Society executive vice president, for "Executive Suite," a discussion of key issues facing the Society.

Health and politics

U. S. Representative Dan Rostenkowski, the sponsor of a controversial bill on hospital cost containment, opened the conference with a summary of his views of the need for health legislation. Others speaking to the issues of government and legislation were R. William Alexander, M.D., chairman of the Council on Governmental Relations, and panelists Robert H. Craig, Jr., and Jerry Rothenberger, of the PMS staff, who reviewed state health legislation and offered suggestions for political action on the local level.

James R. Neely, president of the Hospital Association of Pennsylvania, spoke of the mutual concerns of HAP and PMS and discussed the HAP suit seeking an injunction to stop use of the Health Department's new hospital regulations.

Sidney O. Krasnoff, M.D., president of the Pennsylvania Medical Care Foundation, suggested alternative methods of medical care delivery and reimbursement.

A panel discussion on MAMIS (Medical Assistance Management Information Systems) by deputy secretary for public welfare Thomas L. Hooker and Henry H. Fetterman, M.D., chairman of the Council on Medical Service, concluded the conference's political program.

Legal counsel reports

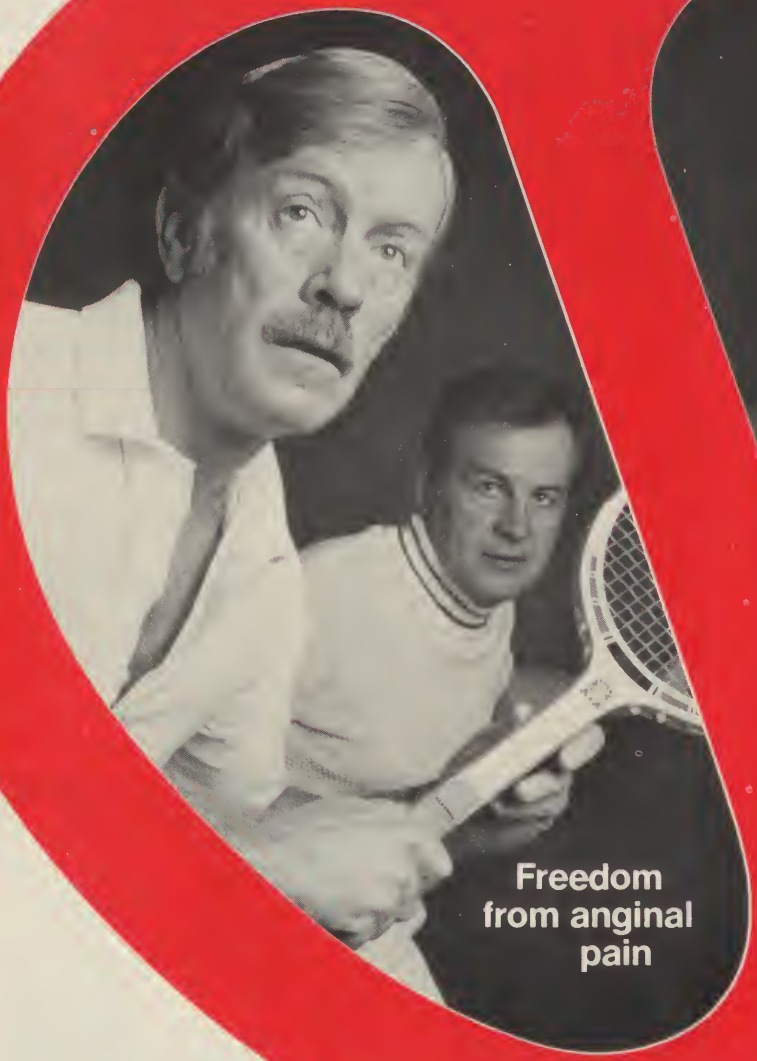
Legal matters were reported on by Fred Speaker, Esq., of the law firm of Pepper, Hamilton and Scheetz, who presented a docket of current PMS litigation. John J. Runzer, Esq., of the same law firm, reviewed the issues leading to Federal Trade Commission scrutiny of the medical profession.

Paul F. Abrams, Esq., adminis-



Questions and comments from the audience were frequent as panelists and speakers opened the floor to informal discussion.

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Officers' Conference 1978



Prayer Breakfast speaker Donald H. Reigel, M.D., told of personal experiences in his examination of medical ethics.

trator of the state's malpractice arbitration system updated his report on medical malpractice litigation which was published in the November 1977 issue of PENNSYLVANIA MEDICINE.

Prayer breakfast

A conference highlight which met with unprecedented attendance was the prayer breakfast which featured as speaker Donald H. Reigel, M.D. Dr. Reigel, chief of neurosurgery at Children's Hospital of Pittsburgh, examined "Inescapable Decision" using examples from his personal experience in pediatric neurosurgery. The breakfast was sponsored by the Society's Commission on Medicine, Religion, and Bioethics.



Lawrence K. Altman, M.D., of the *New York Times* discussed how the press views the medical profession in his Donaldson Memorial Lecture.



Officers were given "A Taste of Practice Management" by Duane M. Johnson, vice president of Practice Productivity, Inc.

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Officers' Conference 1978

Dr. Masland presents PMSLIC status report



David S. Masland, M.D., president of the Pennsylvania Medical Society Liability Insurance Company, announced an anticipated income from premiums of $14-15,000,000 in 1978 and a surplus of approximately $8,100,000. He reviewed the company's operations, direction, and underwriting policy in his report to the Officers' Conference.

Of the 4,370 policies issued thus far, 1,430 are claims made and 2,883 are occurrence type policies. A total of 4,704 policies will be written, with an additional 416 issued to partnerships and corporations. Policies not yet issued have been delayed by inadequate information on the application, nonpayment or incomplete payment of assessments, and the need for further study in individual cases.

Dr. Masland briefly reviewed the PMSLIC underwriting policy, the major points of which are:

- PMSLIC will underwrite only Society members;
- The company has eliminated Argonaut's scheduled surcharge, which was often inequitable;
- PMSLIC has adopted "consent to rate," and surcharges are based on evaluation by the Underwriting Committee of the doctor's entire loss record;
- Fewer surcharges will be made, but some will be penalized more heavily, depending on loss record;
- The Underwriting Committee will recommend cancellation or restriction of coverage when indicated;
- Policyholders have the right of appeal to the PMS Commission on Professional Liability Insurance.

Dr. Masland listed three company goals aimed at keeping down the costs of malpractice insurance: to settle legitimate claims as quickly as possible; to resist claims without merit; and to urge early reporting of claims.

The number of policies issued at press time exceeded 5,000. The ratio of approximately two occurrence type policies to every one claims made policy continues.

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Abrams reviews litigation, announces resignation

Paul F. Abrams, principal draftsman of Act 111 and first administrator of Pennsylvania's arbitration system, presented a status report on medical malpractice arbitration in the state and announced his resignation at the second session of Officers' Conference April 13. The arbitration system has original, exclusive jurisdiction to hear and decide cases in which medical procedure giving rise to claim occurred on or after January 13, 1976, effective date of the Health Care Services Malpractice Act.

Abrams announced that he has recommended to the governor and the General Assembly a "substantial reduction in the annual fee" paid by physicians and nursing homes to fund the arbitration system. He credited the reduction to the "bare bones approach" taken in operating the system and a high rate of success in settling cases.

From January 1 to April 7, 1978, 291 cases were filed with the arbitration office, bringing the total to 761 cases in 27 months of operation. Since January new cases have averaged 21 per week and Abrams projects that the rate will hold steady.

According to the rules of practice and procedure adopted with the Act, a mandatory conciliation conference must be held within six months of the filing of the complaint. "It should be noted," Abrams said, "that 617 of the 761 cases have been filed in the last nine months, so that settlement procedures are just now being applied to the overwhelming bulk of our cases.

"It appears that at least 60 percent of the cases will be settled or discontinued as a result of the mandatory program. The final figure may be closer to 80 or 90 percent. Such a high rate of settlements will substantially reduce the costs of resolving medical malpractice cases."



Arbitration Administrator Paul Abrams

Thus far 83 cases have been settled or discontinued, with an average payment of $59,268.

The Medical Professional Liability Catastrophe Loss (CAT) fund, which pays insurance limits required by the Act, had received premium surcharges amounting to nearly $17,200,000 as of April 7, according to Abrams. "They have been informed of approximately 255 incidents in which the potential liability may exceed the $100,000 basic insurance coverage limits, although it is expected that far fewer will actually result in their financial involvement.

"In January 1978 the CAT fund paid out a total of $2,465,000 in settlement of eight cases above the basic insurance coverage limits," he said.

Abrams concluded his remarks by announcing that he had submitted to the Governor a letter of resignation, effective May 1.

"When I accepted the Governor's offer to develop an alternative to the judicial system for resolving medical malpractice claims, I wanted to establish a statewide system that would substantially shorten the time required to resolve malpractice cases; reduce litigation costs; and operate fairly. I also wanted to administer the program in an efficient and effective manner that would enhance the public's confidence in the state government's ability to serve them with competence, concern, honesty, and an appreciation of their ability to pay the bills.

"I believe these goals have been achieved and that it is time for a new person to take the helm and build on our efforts."

Ewell, Wallace join Health Department

State Health Secretary Leonard Bachman, M.D., recently announced the appointments of Jordan D. Ewell, Jr., as commissioner of the Office of Planning and Development and Robert E. Wallace as deputy secretary for public health programs.

Ewell is responsible for setting current and long-range plans for health services in Pennsylvania, including activities of the Statewide Health Coordinating Council, and need review, primary health care, manpower and insurance, and emergency health services development.

Ewell succeeds Denis J. Lucey, III, M.D., in the top planning post. Dr. Lucey will serve as a special assistant to the secretary until June 30, when he will leave public service.

Robert E. Wallace, executive director of the National Interagency Council on Smoking and Health, New York, was named deputy secretary for public health programs, effective March 20. Wallace replaces William R. Montgomery, Ph.D.

Standard of care must meet national criteria

Fred Speaker, Esq.

An award of more than $320,000 for deafness caused by medical malpractice has been made in a federal case which offers instruction to both the medical and legal professions.

In the case of *Kubrick v. United States,*[1] a 39-year-old man was treated in a Veterans Administration hospital for osteomyelitis in 1968. The osteomyelitis cleared, yet later he developed a hearing loss which ultimately was diagnosed as severe sensorineural, which is permanent and untreatable. He filed suit under the Federal Tort Claims Act[2] in 1972.

The suit involved the use through a hemovac system of a 1 percent solution of neomycin sulfate for nearly two weeks to irrigate the patient's infected area in his right femur. Within three months of his discharge in 1968, the patient began to notice a partial hearing loss and ringing in his ears, which grew progressively worse.

The Court concluded that the administration of the neomycin clearly caused the deafness. The federal government contended that at the time of treatment topical application of neomycin was not known to result in rapid absorption with toxic effects. The patient countered with the argument that the VA physician should have known about the toxic effects, that the prolonged treatment was outrageously high, and that other, effective, non-toxic drugs could have been used.

Standard of care

An important issue which the Court felt it had to decide involved what standard of care to apply to the case. Since an orthopedic specialist was involved, a decision had to be made about whether the standard should be that practiced by the average physician in the same or similar locality, or against a national standard. The court recognized that there was no clear Pennsylvania Supreme or Superior Court decision on the subject, noting that six years before the Pennsylvania Supreme Court had last opened the question of whether Pennsylvania would continue to follow the similar locality rule.[3]

The Court did state that under Pennsylvania law a specialist owes a higher standard of skill, learning, and care than a general practitioner, and concluded:

> We cannot conceive that the highest Court of Pennsylvania, a state containing numerous medical schools, including some of the nation's most prestigious, would fail to adopt the national standard for specialists.[4]

Meeting the standard

The Court decided that the treating physician's lack of knowledge of the properties of neomycin did not meet the national standard because there was generalized knowledge among orthopedic specialists of the hazards of neomycin and its potential for absorption. The Court went on to say:

> However, even if a similar locality standard were to be applied, our findings of fact support the conclusion that the information in question was available to or known by the average specialist in Wilkes-Barre to the same or similar extent as the average specialist in Philadelphia. . . . Finally, we concluded that what was involved was not mere error in judgment but a lack of skill or knowledge, as measured, of course, by the level of medical knowledge in April 1968.[5]

Mr. Speaker is a partner in the law firm of Pepper, Hamilton & Scheetz, which serves as the Society's legal counsel.

Statute of limitations

Under the Federal Tort Claims Act, claims against the U.S. are barred unless they are presented within two years after the claim accrues.[6]

The patient had noticed a hearing loss and ringing in his ears a few months after the operation; he consulted his family doctor, three specialists, and a VA doctor within the year. One of the specialists continued treatment of his progressively worsening condition for three years; although the specialist said during this period that it was highly possible that the condition was caused by the use of neomycin, he did not say it was caused by malpractice. In 1969 the VA informed the patient that there was no evidence of malpractice as a cause and disallowed the claim for compensation. The patient disagreed, and the VA again denied the claim.

In June 1971, another specialist said to the patient for the first time that his condition was caused by malpractice. Suit was started well within two years thereafter.

Pointing out that federal, rather than state, law controlled, the Court cited a long string of cases based on *Quinton v. United States*[7] for the proposition that:

> The test which has been articulated, with considerable uniformity, to determine

"when a claim accrues" is to ascertain the point in time at which the claimant has discovered, or in the exercise of reasonable diligence should have discovered, the acts constituting the alleged malpractice.[8]

The Court went on to say that:

> In legal terms we have concluded that the *Quinton* test creates a rebuttable presumption that knowledge of the causal relationship between treatment and injury is sufficient to alert a reasonable person that there may have been negligence related to treatment. . . . [I]t construes *Quinton* as positing an objective or reasonable man standard in which the success of a plaintiff in tolling the statute depends not only upon his exercising reasonable diligence, but also upon his establishing that there was no reasonable suspicion that there was negligence in his treatment.[9]

The Court thereupon concluded that the patient did not know of acts constituting malpractice until June 1971 and therefore the suit was filed in time.

[1] *435 F. Supp. 435 (E.D.Pa. 1977).*
[2] *28 U.S.C. § 1346.*
[3] Incollingo v. Ewing, *444 Pa. 263, 282 A.2d 206, 214 n.5a (1971).*
[4] Kubrick v. United States, supra *at 188.*
[5] Id. *at 188-9.*
[6] *28 U.S.C. § 2401 (b).*
[7] *304 F.2d 234 (5th Cir. 1962).*
[8] Kubrick v. United States, supra *at 180.*
[9] Id. *at 185.*

Report recommends center expansion

A report setting guidelines for the future development of the Habilitation Center at Elizabethtown was recently forwarded to Governor Shapp by State Health Secretary Leonard Bachman, M.D.

The report is an outgrowth of a legislative mandate requiring the Elizabethtown Committee for Planning and Evaluation to complete a comprehensive utilization review of the center by January 31, 1978. The current fiscal year funding for the hospital was limited to nine months. Future legislative appropriations are contingent upon approval of the report.

Bachman said the committee's recommendations do not essentially change the facility's mission to provide orthopedic and rehabilitative services, but broaden the services to emphasize ambulatory care.

The committee's recommendations include:

- Extension of treatment to persons over 21
- Addition of well-qualified professionals in pediatrics, neurology, psychology, and other fields
- Expanded special education for physically handicapped children under the auspices of the Department of Education
- Development of a regional spinal cord injury center in cooperation with the Hershey Medical Center
- Full accreditation by the JCAH
- Preparation of disabled persons for job opportunities, with cooperation from the Bureau of Vocational Rehabilitation
- Enhanced communication between the hospital and community service providers throughout the state

Last year the hospital treated about 572 persons on an in-patient basis and 6,215 children as outpatients.

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WASHINGTON, Aug. 26, 1920—

Social Security Bill Is Signed; Gives Pensions to Aged, Jobl

Roosevelt Approves Message Intended to Benefit 30,00 Persons When States Adopt Cooperating Laws–He C the Measure 'Cornerstone' of His Economic Progra

WASHINGTON, Aug. 14, The Social Security Bill, pr a broad program of unempl insurance and old age pe and counted upon to benef 20,000,000 persons, became day when it was signed by dent Roosevelt in the pres those chiefly responsible f ting it through Congress.

Mr. Roosevelt calle[d] the m "the cornerstone [of a st] whic[h] is being [built] me[a]s c[om]ple[te] ri[ght]

SENATE APPROVES 18-YEAR OLD VOTE IN ALL ELECTIONS

Amendment to Constitution is Sent to House, Where Passage is Expected

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TRUMAN CLOSES TED NATIONS CONFEREN ITH PLEA TO TRANSLATE CHARTER INTO DEEDS

NEW WORLD HOPE

President Hails 'Great Instrument of Peace,' Insists It Be Used

HISTORIC LANDMARK

Meeting Gives Standing Ovation as Executive Pictures Peace Gain

"If we fail to use it," he declared to the solemn final meeting of the delegates, 'we shall betray all of those who have died in order that we might meet here in freedom and safety to create it.'

"If we seek to use it selfishly—for the advantage of any one nation or any small group of nations—we shall be equally guilty of that betrayal."

Fervent Interpolation

The President, speaking in the auditorium of the War Memorial Opera House, built in memory of sons of the Golden Gate city who gave their lives in the first World War, in which he himself served, seemed to give unconscious expression to the solemn feeling of the occasion when, at the outset of his speech, he interpolated the words, half a hope, half a prayer:

"Oh, what a great day this can be in history!"

Just before the plenary session

SIGN[S] the Draf Ends No

WASHINGTON, Jan. 27, 1973—"With the signing of the peace agreement in Paris today, and after receiving a report from the Secretary of the Army that



PATIENT PACKAGE INSERTS: A CONCEPT WHOSE TIME HAS COME?

The consumer's right to know is an irreversible and desirable trend of the Seventies. It extends, and properly, to a patient's right to know more about his or her prescription medications. One way, gaining favor, is through patient package inserts. Wisely-prepared and properly distributed when medically indicated, they could markedly improve patient knowledge and drug therapy—laudable goals by anyone's standards.

The PMA endorses these goals and will work with government, the health professions and consumers to achieve them.

The Advantages

The concept holds promise of benefits: better patient understanding of the product prescribed, better adherence to the treatment plan, and more awareness of possible side reactions.

Every doctor has had patients who fail to finish antibiotic regimens because they feel better. Some patients assume that if one tranquilizer or analgesic is good, two may be twice as good. Still others fail to report dizziness while on antihypertensive therapy —and so on.

Problems like these might arise less often if the patient received written information in addition to verbal instructions. Some studies suggest that patients are more receptive to such materials, and they more often understand the verbal instructions and follow them, when inserts are used.

The Disadvantages

There are also some potential problems. Obviously, the inserts must be clearly phrased, without extraneous or complex detail. How much information is enough? How can it be kept current? Should all patients receive the same information? Should inserts be included with all drugs? Should only potential problems be listed or are patients better off with a "fair balance" presentation that describes usefulness as well as drawbacks?

These and similar questions require answers, since model inserts have yet to be properly developed and tested. Despite the need for these studies, the FDA is proceeding prematurely with inserts on selected products. We think the Congress is the only place where the matter can be given the proper legal status and direction, particularly since it represents a conceptual change in the legal, medical and social framework of the nation's prescription drug information system.

The Solution

The PMA believes that carefully-devised pilot studies of various kinds of inserts are needed. They should be developed and implemented with full participation by doctors, pharmacists, consumers, communications experts and the drug industry. Such studies will provide reliable pathways to follow, so that inserts will be useful aids to medical practice.

And particularly we think that you should be closely involved in this debate and in these studies and decisions. Otherwise, people with less experience and qualifications may control the purposes, content and use of a tool with considerable promise for improved patient care. It could make a difference in your practice tomorrow, and more importantly, in the health of your patients.

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2. **Do join the Pennsylvania Medical Society Credit Union and start saving regularly. No amount is too large, no amount is too small. How much you save is of less importance than how regularly you save.**

The Pennsylvania Medical Society Credit Union is an independent, cooperative, saving and lending institution chartered under the laws of Pennsylvania and open to members of the Pennsylvania Medical Society, their employees and their families. Members save their money in the credit union in "share" accounts. Members are also eligible to apply for low-cost loans from the credit union. Earnings from the loans—after payment of expenses and setting aside reserves—are shared among the members in the form of dividends on their savings. Money invested in the credit union is absolutely safe, because it is insured by the National Credit Union Administration up to $40,000 per account (the NCUA is an independent agency of the U.S. government).

The credit union is wholly owned and capitalized by the members, who have a democratic share in its management. The members elect, from themselves, a Board of Directors to determine policies; a Credit Committee to act on loan applications; a Supervisory Committee to audit the records.

The Pennsylvania Medical Society Credit Union is the kind of organization you want to join . . . to support . . . to share in the benefits. And you'll want to encourage your spouse and children to become members, too, as well as the people who work for you. Credit union membership is a "fringe benefit" you can provide your employees . . . at no extra cost to yourself!

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Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.
Vasodilan injection, isoxsuprine HCl, 5 mg., per ml.

Dosage and Administration: Oral: 10 to 20 mg., three or four times daily.
Intramuscular: 5 to 10 mg. (1 or 2 ml.) two or three times daily. Intramuscular administration may be used initially in severe or acute conditions.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Parenteral administration is not recommended in the presence of hypotension or tachycardia.

Intravenous administration should not be given because of increased likelihood of side effects.

Adverse Reactions: On rare occasions oral administration of the drug has been associated in time with the occurrence of hypotension, tachycardia, nausea, vomiting, dizziness, abdominal distress, and severe rash. If rash appears the drug should be discontinued.

Although available evidence suggests a temporal association of these reactions with isoxsuprine, a causal relationship can be neither confirmed nor refuted.

Administration of single dose of 10 mg. intramuscularly may result in hypotension and tachycardia. These symptoms are more pronounced in higher doses. For these reasons single intramuscular doses exceeding 10 mg. are not recommended. Repeated administration of 5 to 10 mg. intramuscularly at suitable intervals may be employed.

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Society position on medicaid sent to legislature

The State Society Board of Trustees at a special meeting on April 12 approved a PMS position paper on the Department of Public Welfare's medical assistance program. The paper accompanied an April 19 letter to all members of the State Legislature from Society President John V. Blady, M.D., in which he criticized the Department's budget plans.

Material included in the position paper has been the subject of a continuing, intensive study by the Council on Medical Service. Among the Council's charges are the following:

- DPW and the legislature have failed to provide an efficient medical assistance program. Poor people must be assured of the same opportunity for quality medical care as others in the community.
- Abuse of the drug program is a problem with which the department has not dealt.
- Program administration should be handled by Pennsylvania Blue Shield for effective utilization review and quality control.
- The Health Department should be the state agency supervising quality, availability, and utilization of medical care. DPW's responsibility should be limited to eligibility determination, enrollment, and welfare-related functions.
- The current program is a failure. Many physicians do not participate because of cumbersome administration and grossly inadequate reimbursements.

The text of the position paper, prepared by Ronald M. Bachman, State Society director of economic affairs, follows.

Perspective: Pennsylvania's medical assistance program

The Social Security Amendments of 1965, better known as Public Law 89-97, added two new titles to the Social Security Act: Title XVIII, Health Insurance for the Aged (medicare); and Title XIX, Grants to States for Medical Assistance (medicaid). This discussion will review the latter.

In Pennsylvania, the Medical Assistance program is inadequately funded, inefficiently administered, and diversely regulated, resulting in a program that is unacceptable to many health care providers and that has failed to meet its responsibility to serve the poor.

Costs

The fundamental issue involves health care costs related to the Medical Assistance (M.A.) program. Two years ago, the Pennsylvania Medical Society testified at the House of Representatives Health and Welfare Committee hearings as follows:

"The Society is truly encouraged by the emphasis this committee now places on this issue and we believe that it is extremely important that corrective legislation result from your investigation. The appropriation of $32 million which is the anticipated deficit for the 1975-76 fiscal year budget can be considered as only a stop-gap measure. True and lasting remedies for the problems that plague the medicaid program must be established now. Crisis intervention at the end of each fiscal year would seem an inappropriate solution to a recurring problem. Pennsylvania physicians are not unaware of the actions by their colleagues in other states where suits, paper strikes, and work stoppages have been employed to bring about changes in the medicaid program. While such activities have been seriously discussed in Pennsylvania, you should be aware that organized medicine in this state has consistently discouraged such action as being inimical to proper patient care. It is our strong feeling that the legislative remedy is the only appropriate way to resolve the problem. . . ."

Unfortunately, nothing positive resulted from that legislative hearing and deficit spending has continued. This fiscal year (1977-78) the Department of Public Welfare will fall $35 to $40 million short in the M.A. program and as a result will have no money to reimburse health care providers for about two months.

Governor's budget proposals

But something is being done. Rather than facing directly the adequacy of the funding issue, the administration has proposed a series of cutbacks in benefits as a means of fiscal control. These cutbacks are: implementation of a $.50 co-payment on drugs; a $1.00 co-payment for general medical clinic services (hospital outpatient department and emergency rooms and hospital-related clinics); elimination of several non-mandated services, including pharmacies, dentists, podiatrists, and medical appliances; and elimination of Valium and other related benzodiazepines from the M.A. formulary. Such restrictions, it is felt, could save the state approximately $15 million.

At the same time, there is a proposal to implement a $3 million eyeglass program in Pennsylvania. And while there may be an identifiable need for such a benefit, it is the Society's position that it is wrong to expand the number of optional benefits at the expense of required services.

The Pennsylvania Medical Society is concerned about the escalation of health care costs in recent years, and we are now involved in a variety of voluntary cost containment efforts aimed at reducing the rate of inflation. We encourage experimentation with new concepts in cost containment and utilization control, but it seems incongruous that a state with the resources

and sophistication of Pennsylvania could restrict benefits and limit payments in a program whose funding is in chaos.

The Pennsylvania Medical Assistance program is mandated to pay actual costs to hospitals and nursing homes up to certain established ceilings. Physicians, on the other hand, are reimbursed on the basis of a 1958 fee schedule which was inadequate at that time. A physician in the state of Utah is paid 80 percent of the usual and customary fee under its M.A. program and a physician in Michigan can be reimbursed up to the medicare 75th percentile level. Put more clearly, a Pennsylvania physician can collect $60 for a newborn delivery under Medical Assistance while his counterpart in Michigan receives $300. A surgeon performing a total hip replacement in Pennsylvania is paid $200 (the maximum surgical fee under Pennsylvania medicaid) while a Michigan physician can receive $1,200.

Thus the state does not really purchase care for the individuals for whom it is responsible. It subsidizes charity care provided by participating physicians and others under the Medical Assistance program.

Brand name benzodiazepines

The Department's plans to disallow reimbursement under the M.A. program for brand name benzodiazepines and instead allow payment only for generic chlordiazepoxide were first presented to the PMS Commission on Therapeutics on December 9, 1977. The commission concluded that it could not recommend support of the DPW plan. It was pointed out that there is a disparity between one of the Department's stated concerns, i.e., abuse of these drugs (specifically, Valium) and the savings resulting from limiting payment to generic chlordiazepoxide.

The Society believes the potential for recipient abuse will exist whether or not payment is limited to generic substitutes for brand name drugs. The Society also believes there is a lack of documented pharmacologic and clinical evidence to demonstrate that all the compounds in question are, in fact, equivalent. The DPW literature search on the clinical equivalency of brand name benzodiazepines and generic chlordiazepoxide seems to be somewhat limited.

It is the position of the Pennsylvania Medical Society that Medical Assistance recipients should have an equal opportunity to purchase any drugs available to the general public, as determined by a physician's professional judgment, and that it is discriminatory to single out M.A. recipients and limit, by regulation, their access to medically appropriate therapy.

Abuse of drug program

The Society recognizes that there must be controls to minimize increasing health care costs. It is the Society's position that controls must be developed professionally and not based on unreasonable and irrational regulations which jeopardize the quality of medical care and erect barriers to availability. Consistent with this position, the Society's Medical Care Foundation operates its Professional Drug Utilization and Quality Appraisal Program as part of the Capital Blue Cross contract to administer the Medical Assistance drug program. Through this program, local committees of physicians and pharmacists evaluate profiles of drug prescribing and dispensing patterns and make recommendations to correct patterns which reflect possible overuse or abuse of the drug program.

The Society believes the foundation's program has had, and can continue to have, a positive effect in controlling over-utilization and abuse. DPW must institute an effective procedure for dealing with recipients who are found to be abusing the program. It is unfair and discriminatory to penalize all recipients simply because some are misusing M.A. benefits.

Since July 1977 Capital Blue Cross has forwarded the names of hundreds of recipients (involving thousands of dollars) to DPW for further investigation of possible abuse. A significant number of cases involved the use of brand name benzodiazepines, all of which have been reviewed by the foundation's local drug utilization review committees (DURCs).

However, information available to the Society indicates the department has taken no corrective action on these cases. This contributes to the frustration of the members of local DURCs who review profiles representing apparent abuse month after month, with no action taken by DPW to investigate and correct the situations.

Proposed co-pay provisions

DPW plans to institute co-pay provisions for certain benefits under the Medical Assistance program which now are covered on a "first dollar" basis. PMS questions whether such an approach will have any positive effect on the M.A. program. The program is intended for poor people who do not have the resources to purchase health care. The net effect of co-pay, in many instances, will mean simply a reduced reimbursement to the provider, whose reimbursement is already limited under the M.A. program. Finally, research on the effect of co-pay and deductible provisions on utilization of services is not conclusive. One study determined that co-payment for ambulatory and drug services for low income families deterred use of doctors' services, resulting in reduced diagnostic tests and preventive medicine and increased hospital utilization.

A study by the University of Michigan School of Public Health found that co-payments and deductibles have different effects, depending on type of medical condition, social class, and income. The differential effect by type of condition is likely to be useful socially because it tends to depress use for less serious and less urgent conditions. When this allocation is made through fiscal deterrents, however, it can easily go wrong. Because the patient's medical knowledge is limited, preventive services may be foregone and access to proper professional evaluation may be inhibited, or care for severe, long-lasting illness may be curtailed.

While cost sharing may be a useful means for reducing costs in many areas, it may well have a reverse effect when applied to delivery of health care.

Program administration

Pennsylvania Blue Shield is the largest of the nation's 72 Blue Shield plans. It administers nearly all of Title XVIII (medicare) in Pennsylvania,

as well as in-hospital physicians' services under Title XIX (medicaid). As a result, Pennsylvania Blue Shield handles health benefits for more than 8 million Pennsylvanians—two of every three residents. It possesses a massive technical and computer capability and currently maintains medicare data which are important in administering the cross-over medicare/medicaid claims. It has the expertise to do effective utilization review and quality control.

The Pennsylvania Medical Society has recommended many times since 1967 that Blue Shield be designated the fiscal intermediary for the Pennsylvania Medical Assistance program. The Society feels strongly that medicaid recipients should be provided with a standard Blue Cross/Blue Shield card so that they may truly be on equal terms in the medical marketplace.

Program regulation

Another of the Society's positions adopted in 1967 continues to be valid and appropriate. Title XIX is a program which has more health than welfare aspects. It is therefore a program in which both the state health and state welfare departments have legitimate responsibilities to perform. Sound public policy dictates that health functions should be placed in the state health agency and welfare functions in the state welfare agency. Therefore, it is the position of the Pennsylvania Medical Society that the Department of Health be designated the single state agency for Title XIX. It should be charged with the responsibility of supervising the quality and availability of medical care, establishing utilization and medical audit procedures, determining physician's fees, and handling all other matters related to medical care and the medical profession's part in the program. The responsibility of the Department of Public Welfare should be limited to eligibility determination, enrollment or registration, and those functions that require a welfare orientation.

Regarding eligibility, the Society considers that eligibility rolls and reimbursement programs have been expanded far beyond those contemplated or mandated by the original law. Policing the rolls is a difficult job, but one that is certain to be cost effective. No one knows this better than the practicing physician who treats a fashionable looking college student only to be presented with a medicaid card.

Fraud and abuse

The Society has consistently recommended that the Department of Public Welfare report for action to the State Board of Medical Education and Licensure known cases of physician fraud and/or abuse. However, the fact that the medicaid program pays out a significant amount of money to a particular physician does not necessarily mean the physician is abusing the program. In many instances, the participating physician works 12 to 14 hours per day treating hundreds of patients a week because other providers in the area have refused to participate in the M.A. program.

What can be done?

Pennsylvania's Medical Assistance program in its present form is a failure. A large percentage of independent health care providers do not participate in the program because of the cumbersome administration of the program and grossly inadequate reimbursement levels. Few physicians can afford to see a large volume of M.A. patients because at $6.00 per visit office overhead costs quickly offset Medical Assistance income.

Beyond the matter of fees, the program is a failure because it is based on a system of disincentives to participate. Under the Pennsylvania Medical Assistance program:

1. Only 82 procedures can be reimbursed on an outpatient basis (clearly, an encouragement to hospitalize patients unnecessarily);

2. Physicians must complete a separate invoice for each patient even if several members of a family are treated at the same time;

3. Forms are considered invasive and burdensome;

4. Invoices must be typed to insure prompt payment;

5. Medicare/medicaid cross-over claims are difficult and time-consuming to pursue;

6. Payment vouchers do not identify the patients for whom payment is made;

7. Physicians are referred to as "vendors."

These and other related issues have been discussed periodically by the Society's Council on Medical Service and representatives of the Department of Public Welfare. In fairness to the Department, the Society is aware that it has in the past requested increased payment for physicians' services in the budget only to have it eliminated by the Legislature. Consistent with a request of the Council on Medical Service, the Department requested permission from the budget secretary to reimburse physicians for all procedures which could be performed on an outpatient basis. This could result in substantial savings because thousands of treatments done annually on an inpatient basis could be done on an outpatient basis. No response to that recommendation, made early in 1977, has been received.

Conclusion

The Department of Public Welfare and the Pennsylvania Legislature should commission projects to prove or disprove some of the theories and concerns brought by the Pennsylvania Medical Society and others. The Commonwealth of Pennsylvania has established itself as having one of the lowest—if not the lowest—reimbursement levels for physicians in the nation. There can be little doubt that as disincentives to participation continue to mount, care to recipients will be directed to the expensive inpatient setting.

The Pennsylvania Medical Society believes that the poor citizens of the Commonwealth should have the same opportunity to receive quality medical care as other members of their community. The Department of Public Welfare and the Pennsylvania Legislature have failed in their obligation to provide an efficient and effective Medical Assistance program; as a consequence, medicaid recipients are placed at a disadvantage when seeking medical care. The Society believes it is time that this issue is promptly and properly addressed.

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Cost containment — challenge of our time

In November 1977 Congressman Dan Rostenkowski (D-Ill), chairman of the House Ways and Means Subcommittee on Health, issued a challenge to the health field to develop a voluntary cost containment program. Stating that government controls "should be a last resort," Rep. Rostenkowski directed that challenge to the American Medical Association, the American Hospital Association, and the Federation of American Hospitals.

In a joint statement, these organizations founded the National Steering Committee of the Voluntary Cost Containment Program which is made up of representatives from all sectors of the health field who have an influential role in cost containment. Their stated goal is voluntary reduction of the rates of increase in hospital and health care costs. They have asked that state organizations be formed as extensions of this committee and that attempts to implement these goals be carried out.

Emphasizing that preparation is vital to the success of this program, the American Medical Association has endorsed a program aimed at medical schools, medical students, and house staff to educate physicians about costs of medical care. The AMA also is encouraging the development of local cost awareness programs through conferences, seminars, and workshops.

Briefly, the main points of the proposal, entitled the Voluntary Hospital Cost Containment Act of 1978 (HR-6575), define the scope and nature of the program: (1) pledge to reduce spending by 2 percent in 1978 and each year thereafter, (2) mechanism of government controls if the voluntary program should fail, (3) exemptions of wages, fuel, and malpractice, (4) exceptions to and penalties resulting from excess of revenue cap, and (5) recognition of state programs.

There are, of course, many other provisions in the act. Interestingly, in an amendment, the act states that HEW cannot refuse to recognize a state program solely because it has had no experience at cost controls. The federal government's record in this area is somewhat lacking so that denial of a state program based only on experience would be absurd.

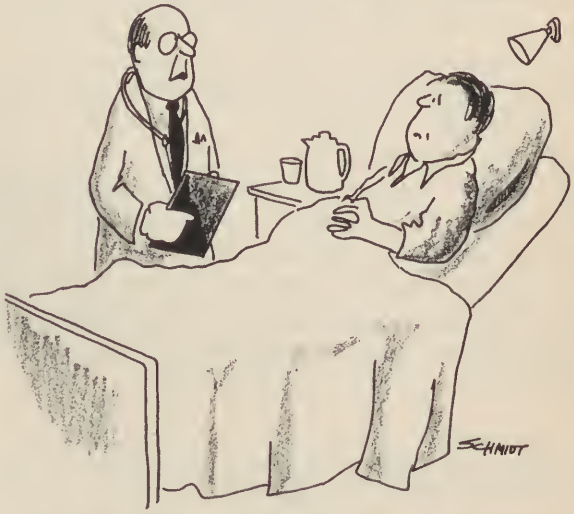
At its initial meeting on March 22, 1978 the Pennsylvania Committee on Voluntary Cost Containment embraced the 15-point program of the National Committee. This program includes the general cost control principles of the law as well as some specific suggestions. Tightened utilization review procedures; development of multi-hospital systems; requests of hospital suppliers, insurance carriers, and federal and state health agencies to carry out cost effective studies and alternatives; and public education efforts are recommended.

The Pennsylvania Voluntary Cost Containment Committee program depends on voluntary initiatives by hospitals and physicians. They have asked for formal support from both in the form of resolutions to be adopted by hospital boards of trustees and medical executive committees. It is within our best interests to comply with this request and to work actively toward the stated goals. A day rarely goes by that a comment about government intervention in medical care is not heard. We have been given an opportunity to show that health facilities can regulate themselves to fend off further government encroachment.

It should be obvious to physicians that we cannot wait until a fatality occurs at the intersection to put up the red light. We will have to search for ways to contain costs — *consistent with sound medical practice* — to prevent the federal government from calling the signals. Increased use of hospital outpatient facilities and same-day surgery, when possible, have been suggested.

The goal of high quality medical care rendered at the lowest possible cost can be met if a unified effort is made. Private sector cost containment methods can and should be more efficient than government regulation. It only remains for us to prove it.

David A. Smith, M.D.
Medical Editor



You're coming along fine, but I can't release you until you're strong enough to face the cashier.

in my opinion

Shunning

I've been following the seven-year legal fight between William F. Buckley, Jr., and the American Federation of Television and Radio Artists (AFTRA) with some interest, and recently I read that a compromise of sorts has been effected. No longer does AFTRA require that Buckley or any radio or television artist be a member so long, please note carefully, as he pays the equivalent of dues to the federation. Union officials, while welcoming the "dues" victory, express great concern that the union can no longer require employes to adhere to its rules and regulations or be bound by strikes. Since Buckley must pay "dues" to a union, he complains, certainly he is not a winner. It's a stand-off compromise.

Douglas Fraser, new president of the United Auto Workers, commented on the Buckley-AFTRA attunement on a television talk show recently, and from memory I will try to convey his thoughts because I think they have application to physicians and organized medicine. Fraser, of course, said it is quite proper that AFTRA or any union require 100 percent membership among employes. With metaphors flying, he likened a body of employes and their union to a village in which no one disputes that taxation (dues) is necessary to provide police and fire protection, sanitation service, water, streets, lighting, parks—those things that enrich communal (union) existence. The union equivalents are comfortable wages, safe working conditions, hospitalization insurance, major medical insurance, pension plans, and the like. Everyone pays because everyone benefits.

Fraser's reasoning is fairly simplistic but not enough to strip it of all worth. When my fellow physicians ask me about organized medicine, these are some of the questions that weary me most: Why should I belong to organized medicine? What does the AMA (PMS, county society) do for me? I don't approve of PMS policy, so why should I join?

You've heard them all, maybe asked some. It is very difficult for me to divine how a sensible, prudent, socially aware physician can fail to support organized medicine. A laggard physician here, eccentric in sense of commonweal, may be eccentric in other areas, someone to be vigilant about. Let me state frankly that among the many criteria I employ for choosing referral specialists is their presence in or absence from our ranks.

We are not a union, we cannot enforce membership—we can't extort Buckley-AFTRA compromises because we don't have the clout. Yet there is a weapon that we use too infrequently. I call it revealed sense of displeasure. We run up against querulous nonmember physicians almost every day; we're friends, classmates, or practice colleagues of most of them in relationships that are almost always cordial and fraternal. Why not prompt them, goad them, shame them with our disappointment that the burden of support for organized medicine is on us, not them. Chiefs, for example, should let their young subordinates know that society membership adorns a career. Let apostates and nonmembers appreciate that, competence factors being equal, our consultation referrals go to society members. Medical school faculty physicians must be made to realize that lecturers and continuing education teachers from their ranks will be society members whenever possible.

It seems apparent to me that we have it in our hands to create a sense of the pariah among defectors and non-members. This is the only way we'll recruit. Not by retailing benefits of membership—we've done that to death—but by forcing the belief that nonmembers are somehow beyond the pale. Recruitment by shunning, you say? Yes, that fits it exactly. Shunning. Medicine is in perilous straits. We need all 395,000 physicians in America to hear the tocsin, not just the scant one half who answer now.

Let's use judicious shunning as a warp to membership. Let's courteously but firmly separate ourselves from recalcitrants. Membership in organized medicine will soon become irresistible for all.

Sam Faris, M.D.
Glenside

The author is a delegate to the State Society House of Delegates, past president of the Montgomery County Medical Society, and editor of the society's Bulletin, *where this commentary first appeared in the March 1978 issue.*

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MDs in the news

William S. Gordon, M.D., of Linglestown, was one of a group of physician joggers who participated with a field of 4,700 runners in the Boston Marathon in April. Dr. Gordon's eleventh Marathon run, in which he competed in the over-50 class, was completed in three hours and two minutes.

Bernard L. Segal, M.D., Villanova, has been appointed director of the William Likoff Cardiovascular Institute of Hahnemann Medical College and Hospital, succeeding Dr. Likoff in that position. Dr. Segal, professor of medicine at Hahnemann, had been director of the institute's division of clinical services.



Dr. Segal



Dr. Hawkins

Richard A. Hawkins, M.D., and **James J. Richter, M.D.,** have been named to staff the new division of anesthesia and metabolic research in the department of anesthesia at the Pennsylvania State University College of Medicine, Hershey. Dr. Hawkins, who will head the division, was formerly associate professor of neurosurgery and physiology at New York University Medical Center. Dr. Richter comes to Hershey from the University of Wisconsin, where he was an assistant professor of anesthesiology.

Guy H. Chan, M.D., Philadelphia, has been named chairman of the department of ophthalmology at Temple University Medical Center. Dr. Chan, who has been acting chairman since 1975, is the creator of innovative equipment and systems, such as Chan's Wrist Rest for use in ophthalmic microsurgery and a modification of the suction, infusion, and tissue extractor for anterior segment surgery.

Two physicians at Temple University Medical Center recently were selected to receive the top annual awards presented by the Philadelphia County Medical Society. **George P. Rosemond, M.D.,** of Malvern, professor of surgery and former department chairman, was selected for the Strittmatter Award, the society's highest honor. **Emmanuel M. Weinberger, M.D.,** of Elkins Park, was named the society's Practitioner of the Year.

The following physicians are among the officers of the Philadelphia PSRO: **Jonathan E. Rhoads, Sr., M.D.,** president; **Jerome Miller, D.O.,** vice president; **George R. Fisher, III, M.D.,** secretary; **John Hall, Jr., M.D.,** chairman, Board of Directors; and **Avery W. Beverly, M.D.,** Board vice chairman.

Patrick J. Ferrarro, M.D., of Clarks Summit, and coauthor Robert A. Cecchini, Esq., recently published a research paper in the *Journal of Legal Medicine* entitled "The Standard of Care in Emergency Room Procedure." Dr. Ferrarro is director of critical care at Community Medical Center and medical director of Emergency Services of Northeastern Pennsylvania.

Anthony J. Sattilaro, M.D., has been named vice president and chief executive officer of Methodist Hospital, Philadelphia. A graduate of Harvard Business School's program in health systems management, Dr. Sattilaro has served as Methodist's director of anesthesia, health services review, and development.

Sol Sherry, M.D., chairman of medicine at Temple University Medical Center, recently was awarded the rank of master by the American College of Physicians. Dr. Sherry, who shared the ACS's highest award with only nine other physicians, was cited for exceptional service to medicine and the college.

Leslie Angus, M.D., assistant superintendent of Danville State Hospital, and **Francis W. Davison, M.D.,** senior consultant in the department of otolaryngology at Geisinger Medical Center, recently received citations from the State Society for 50 years of medical service.

Newton Hornick, M.D., of Pittsburgh, has been elected vice president of the American College of Radiology. Dr. Hornick, a past president of the Pennsylvania Radiological Society, is senior radiologist at Suburban General Hospital.



Elsie Reid Carrington, M.D. (center), Ardmore, professor emerita and former chairman of obstetrics and gynecology at the Medical College of Pennsylvania, was honored recently in retirement ceremonies. With Dr. Carrington are Jan Schneider, M.D. (left), Germantown, current chairman of the department, and J. Robert Willson, M.D., chairman of that department at the University of Michigan Medical School and recipient of the first Elsie Reid Carrington Visiting Professorship.

Time is the test of all things.

1954
1978



BRIEF SUMMARY

Indications: Oral potassium therapy for the prevention and treatment of hypokalemia which may occur secondary to diuretic or corticosteroid administration. May be used in the treatment of cardiac arrhythmias due to digitalis intoxication.

Contraindications: Severe renal impairment with oliguria or azotemia, untreated Addison's disease, adynamia episodica hereditaria, acute dehydration, heat cramps and hyperkalemia from any cause.

Precautions: Potassium intoxication by oral administration rarely occurs in patients with normal kidney function, however, potassium supplements must be administered with caution, since the amount of the deficiency or daily dosage is not accurately known. Frequent checks of the clinical status of the patient, and periodic ECG and/or serum potassium levels should be made. High serum concentrations of potassium ion may cause death through cardiac depression, arrhythmias or arrest. This drug should be used with caution in the presence of cardiac disease.

In hypokalemic states, especially in patients on a low-salt diet, hypochloremic alkalosis is a possibility that may require chloride as well as potassium supplementation.

Adverse Reactions: Nausea, vomiting, diarrhea, and abdominal discomfort have been reported. The most severe adverse effect is hyperkalemia.

Overdosage: Potassium intoxication may result from overdosage of potassium or from therapeutic dosage in conditions stated under "Contraindications". Hyperkalemia, when detected, must be treated immediately because lethal levels can be reached in a few hours.

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1. Goldberg HL, Finnerty RJ, Cole JO: Doxepin: Is a single daily dose enough? *Am J Psychiatry* 131:1027-1029, 1974.

Brief Summary of Prescribing Information
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Warnings—Adapin has not been evaluated for safety in pregnancy. No evidence of harm to the animal fetus has been shown in reproductive studies. There are no data concerning secretion in human milk, nor on effect in nursing infants.

Usage in children under 12 years of age is not recommended. MAO inhibitors should be discontinued at least two weeks prior to the cautious initiation of therapy with this drug, as serious side-effects and death have been reported with the concomitant use of certain drugs and MAO inhibitors.

In patients who may use alcohol excessively potentiation may increase the danger inherent in any suicide attempt or overdosage.

Precautions—Drowsiness may occur and patients should be cautioned against driving a motor vehicle or operating hazardous machinery. Since suicide is an inherent risk in depressed patients they should be closely supervised while receiving treatment. Although Adapin has shown effective tranquilizing activity, the possibility of activating or unmasking latent psychotic symptoms should be kept in mind.

Adverse Reactions—Dry mouth, blurred vision and constipation have been reported. Drowsiness has also been observed.

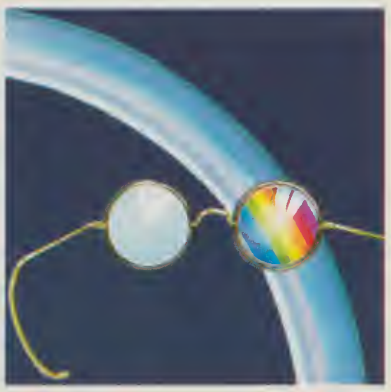
Adverse effects occurring infrequently include extrapyramidal symptoms, gastrointestinal reactions, secretory effects such as sweating, tachycardia and hypotension. Weakness, dizziness, fatigue, weight gain, edema, paresthesias, flushing, chills, tinnitus, photophobia, decreased libido, rash and pruritus may also occur.

Dosage and Administration—In mild to moderate anxiety and/or depression: 25 mg t.i.d. Increase or decrease the dosage according to individual response. Daily dosage, up to 150 mg may be taken at bedtime without loss of effectiveness. Usual optimum daily dosage is 75 mg to 150 mg per day not to exceed 300 mg per day.

Antianxiety effect usually precedes the antidepressant effect by two or three weeks.

How Supplied—Each capsule contains doxepin, as the hydrochloride: 10 mg, 25 mg, 50 mg and 100 mg capsules in bottles of 100 and 1000.

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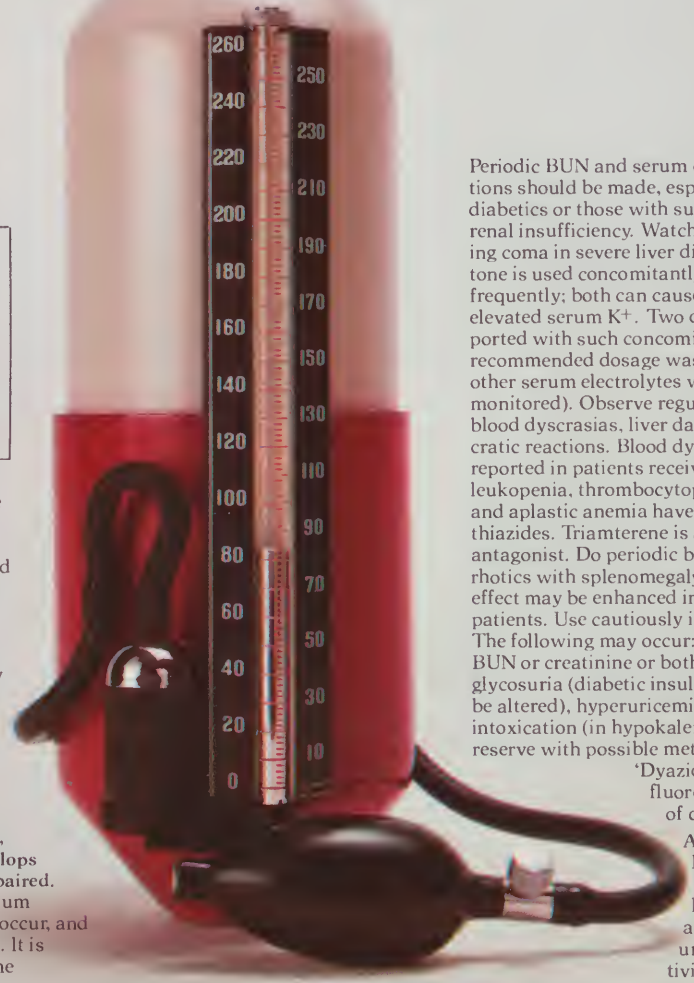
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This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

* **Indications:** When the combination represents the dosage determined by titration: Adjunctive therapy in edema associated with congestive heart failure, hepatic cirrhosis, the nephrotic syndrome. Corticosteroid and estrogen-induced edema, idiopathic edema; hypertension, when the potassium sparing action of triamterene is warranted. (See Box Warning.) Routine use of diuretics in healthy pregnant women is inappropriate; they are indicated in pregnancy only when edema is due to pathological causes.

Contraindications: Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K^+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K^+ frequently; both can cause K^+ retention and elevated serum K^+. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine.

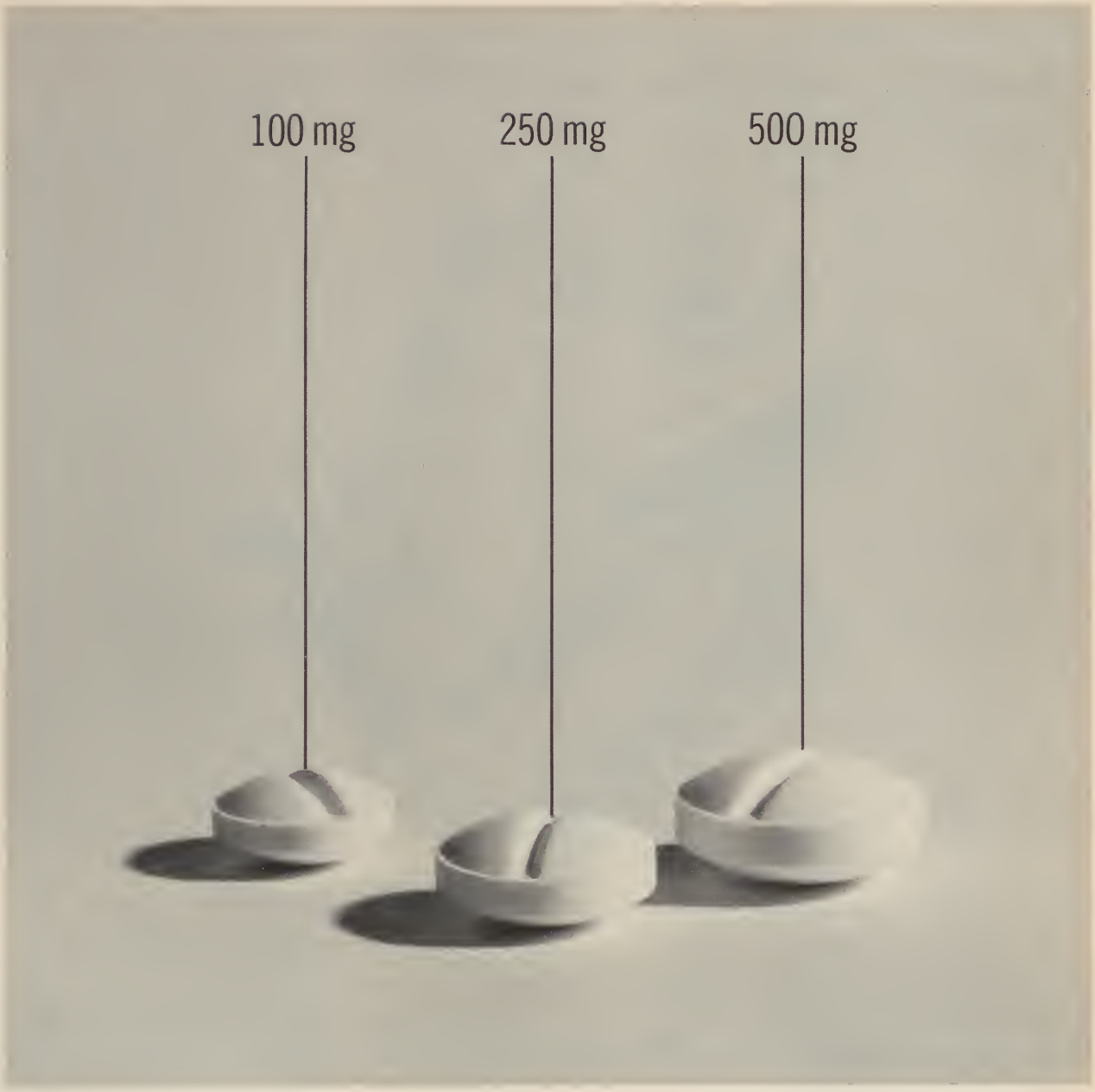
Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

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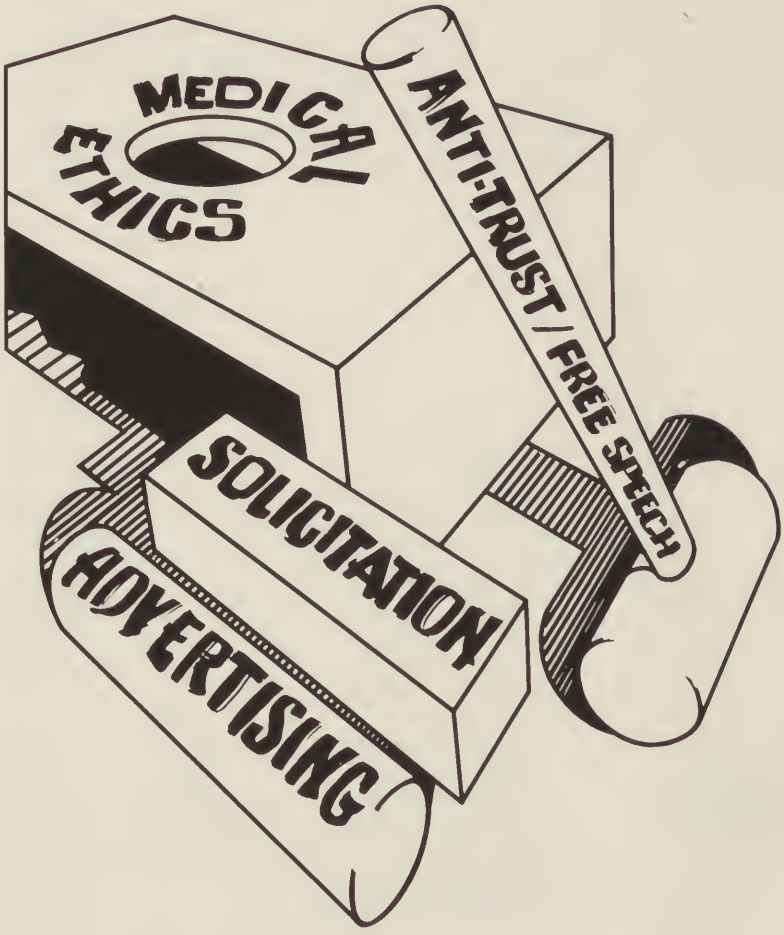
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Advertising, solicitation, and medical ethics

Fred Speaker, Esq.



Strictly speaking, the decision of the United States Supreme Court authorizing attorney advertising[1] had no effect on the practice of medicine in Pennsylvania. It should not be ignored, however, for it must be examined to see how the Constitution and antitrust laws may be applied in the future.

In that case the Court considered an advertisement placed by attorneys which said, "DO YOU NEED A LAWYER? Legal Services at Very Reasonable Fees," and then listed five routine legal procedures with their fees and the names and address of the attorneys. The Arizona Bar Association filed a complaint about this advertisement, claiming that it violated a disciplinary rule adopted by the Supreme Court of Arizona which stated in part:

> A lawyer shall not publicize himself . . . as a lawyer through newspaper or magazine advertisements, radio or television announcements, display advertisements in the city or telephone directories or other means of commercial publicity. . . .[2]

The Arizona Bar Board of Governors voted one-week suspensions which were upheld by the Arizona Supreme Court.

When the case reached the U.S. Supreme Court, the punishment of the attorneys was attacked on two grounds: (1) violation of the antitrust law, and (2) infringement of the constitutional right of free speech. The Court held unanimously that prohibition of the advertisement by the court rules was not subject to antitrust attack under the Sherman Act because it was the state that prohibited it. The restraint was the "affirmative command" of the sovereign and thus was exempt under a doctrine established a third of a century earlier.[3]

But this state prohibition of advertising was held, in a 5-4 vote, to violate the federal constitutional provisions requiring free speech. Carefully stating that it was not considering advertising concerning the quality of services, the majority concluded:

> The constitutional issue in this case is only whether the State may prevent the publication in a newspaper of appellants' truthful advertisement concerning the availability and terms of routine

Mr. Speaker is a member of the law firm of Pepper, Hamilton & Scheetz, which serves as the Society's legal counsel.

legal services. We rule simply that the flow of such information may not be restrained. . . .[4]

What about medicine?

In Pennsylvania, for medicine, the circumstances are entirely different. There is no explicit court or statutory prohibition of advertising by physicians. Organized medicine prohibits solicitation by doctors—not advertising. Section 5 of the American Medical Association's Principles of Medical Ethics provides in part that the physician "should not solicit patients." Its Judicial Council adds:

> Advertising.—The Principles do not proscribe advertising; they proscribe the solicitation of patients. Advertising means the action of making information or intention known to the public. The public is entitled to know the names of physicians, the type of their practices, the location of their offices, their office hours, and other useful information that will enable people to make a more informed choice of physician.
>
> The physician may furnish this information through the accepted local media for advertising or communication, which are open to all physicians on like conditions. . . .
>
> If the physician, at his opinion, chooses to supply fee information, the published data may include his charge for a standard office visit or his fee or range of fees for specific types of services, provided disclosure is made of the variable and other pertinent factors affecting the amount of the fee specified. The published data may include relevant facts about the physician, but false, misleading, or deceptive statements or claims should be avoided.
>
> Local, state, or specialty medical associations, as autonomous organizations, may have ethical restrictions on advertising, solicitation of patients, or other professional conduct of physicians that exceed the Principles of Medical Ethics. Furthermore, specific legal restrictions on advertising or solicitation of patients exist in the medical licensure laws of at least 34 states. Other states provide regulation through statutory authority to impose penalties for unprofessional conduct.
>
> Solicitation.—The term "solicitation" in the Principles means the attempt to obtain patients by persuasion or influence, using statements or claims that (1) contain testimonials, (2) are intended or likely to create inflated or unjustified expectations of favorable results, (3) are self-laudatory and imply that the physician has skills superior to other physicians engaged in his field or specialty of practice, or (4) contain incorrect or incomplete facts, or representations or implications that are likely to cause the average person to misunderstand or be deceived.[5]

It should be noted that the items of permissible advertisement for physicians in the AMA's view are essentially what was permitted for lawyers by the U.S. Supreme Court—the name, address, and type of practice of the practitioner and the fees to be charged.

Even if these ethical restraints were more stringent, it is most unlikely that they would run afoul of the prohibitions against denial of free speech contained in the federal constitution. The First and Fourteenth Amendment protection of free speech is, by their terms, limited to control of federal or state action.[6] Private action may become so intertwined with governmental policies,[7] by engaging in conduct usually governmental[8] or becoming enmeshed by licensing and regulation,[9] to be effectively governmental in nature. Or the theory may mature that associations created by the state are subject to constitutional limitations affecting state action.[10] But, at this point in the development of law, there should be little fear that the Pennsylvania Medical Society or any of its component societies will be bound by the strictures of the rule against infringement of free speech.

Can it happen here?

The possibility of action against a physician's advertising, brought by the State Board of Medical Education and Licensure and resulting in infringement of free speech, is theoretically possible. Before enactment of the new Medical Practice Act, the statute gave the Board the authority to suspend or revoke a license to practice medicine "upon satisfactory proof of grossly unethical practice."[11] In theory, unethical advertising could have been a target. The Pennsylvania Superior Court has approved the revocation of a license of a physician who used an unlicensed man to diagnose and treat patients. The court stated:

> It cannot be doubted that appellant's conduct of aiding and abetting an unlicensed person in the unlawful practice of medicine, manifestly and flagrantly violative of the purpose of the Act, was "grossly unethical practice."[12]

The Pennsylvania Supreme Court has cast considerable doubt on the value of this holding that punishment for "grossly unethical practice" is justified, saying that the case's "validity is questionable."[13] The new Medical Practice Act, enacted in 1974,[14] no longer has a provision expressly prohibiting "grossly unethical practice," which presumably could have been used to enforce the provisions of the Principles of Medical Ethics. The Act does, however, authorize revocation or suspension of a license for:

> Being guilty of immoral or unprofessional conduct. Unprofessional conduct shall include any departure from, or the failure to conform to, the standards of acceptable and prevailing medical practice. . . .[15]

Although this terminology has not yet been construed in a reported case, it is possible that it will be considered to include unethical conduct. In a more recent Superior Court case, the following language was quoted with approval:

> The phrase 'grossly unethical practice' can only be considered as signifying those breaches of the trust, confidence and reliance, necessarily attendant upon the intimate relationship of physician and patient, which amount to gross abuses of the standards of professional conduct generally recognized as essential to the proper practice of medicine and surgery.[16]

Although this possible application should not be overemphasized, it is thus possible that the State Board could move against a physician who is engaged in advertising significantly beyond that allowed by medical ethics. In such a case, the prohibition against state action infringing free speech would clearly come into play.

Restraint of "trade"

Organized medicine can relax substantially about the threat of the federal constitution. But it should be greatly concerned about the effect of the antitrust laws.

The decision of the United States Supreme Court in *Goldfarb v. Virginia State Bar*[17] signalled a major new thrust against professional associations in the antitrust field. In that case the Court held that there was a violation of the Sherman Act in the publication by a county bar association of a minimum fee schedule. The Sherman Act provides that:

> Every contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several States, or with foreign nations, is declared to be illegal.[18]

The Supreme Court referred to the cases upon which the county bar relied for its position that Congress never intended to include the learned professions within the terms "trade or commerce" in § 1 of the Sherman Act, as:

> citations . . . to passing references in cases concerned with other issues and, more important, until the present case it is clear that we have not attempted to decide whether the practice of a learned profession falls within § 1 of the Sherman Act. In [*United States v.*] *National Assn. of Real Estate Boards,* [339 U.S. U.S. 485, 492 (1950)], we specifically stated that the question was still open . . . as we had done earlier in *American Medical Assn. v. United States,* 317 U.S. 519, 528 (1943).[19]

The Supreme Court stated that no explicit statutory exemption or legislative history supported the county bar's contention, and rejected the argument that "competition is inconsistent with the practice of a profession because enhancing profit is not the goal of professional activities; the goal is to provide services necessary to the community."

The Court found that that "classic" distinction between professions and trades, "loses some of its force when used to support the fee control activities involved here."[20] The Court characterized the county bar's arguments as seeking a total exclusion for learned professions from antitrust regulation. The Supreme Court responded that such an exemption would allow lawyers "to adopt anticompetitive practices with impunity" and would be inconsistent with Congressional intent.

> The nature of an occupation, standing alone, does not provide sanctuary from the Sherman Act, . . . nor is the public service aspect of professional practice controlling in determining whether § 1 includes professionals. . . . Congress intended to strike as broadly as it could in § 1 of the Sherman Act, and to read into it so wide an exemption as that urged on us would be at odds with that purpose.[21]

Advertising and antitrust

There is an important modification of the Court's holding that there is no professional exemption from antitrust regulation contained in a footnote to its opinion which reads:

> The fact that a restraint upon a profession as distinguished from a business is, of course, relevant in determining whether that particular restraint violates the Sherman Act. It would be unrealistic to view the practice of professions as interchangeable with other business activities, and automatically to apply to the professions antitrust concepts which originated in other areas. The public service aspect, and other features of the professions, may require that a particular practice, which would properly be viewed as a violation of the Sherman Act in another context, be treated differently. We intimate no view on any other situation than the one with which we are confronted today.[22]

It is the language of this footnote, particularly the passage indicating that it would be inappropriate to automatically apply to the professions concepts developed in other areas, that could provide organized medicine with the greatest support in arguing that the ethical rules against solicitation or excessive advertising are not automatically an antitrust violation. In contrast, there seems to be no merit to a contention that there is a total exemption of any professional activities from the antitrust laws.

Thus if a state or component medical society moves against a physician, charging an ethical violation in advertising, that society may be found to have violated the antitrust laws. Although no case has yet been reported holding that an association for professionals cannot restrict advertising by its members, an agreement among profit-making corporations to restrict advertising has been held to be an unlawful restraint of trade.[23]

Accordingly, enforcement by organized medicine of any rules against advertising or solicitation must be undertaken only with great care and concern about its legal implications.

1/ Bates v. State Bar of Arizona, *U.S., 45 U.S.L.W 4895 (1977).*

2/ Code of Professional Responsibility, Disciplinary Rule 2-101(B), embodied in Rule 29(a) of the Supreme Court of Arizona, 17A Ariz. Rev. Stat. (1976 Supp.) p. 26.

3/ Parker v. Brown, *317 U.S. 341 (1943).*

4/ Bates v. State Bar of Arizona, *supra at 4904.*

5/ AMA Judicial Council, "Opinions and Reports" §6.00 (1977).

6/ Emerson, "The System of Freedom of Expression" p. 676 (1970).

7/ See Evans v. Newton, *382 U.S. 296 (1966).*

8/ See Marsh v. Alabama, *326 U.S. 501 (1946).*

9/ See Red Lion Broadcasting Co. v. FCC, *395 U.S. 367 (1969).*

10/ See Berle, "Constitutional Limitations on Corporate Activity - Protection of Personal Rights From Invasion Through Economic Power," 100 U. of P.L. Rev. 933 (1952).

11/ 63 P.S. § 410 (repealed).

12/ Pennsylvania State Board of Medical Education & Licensure v. Ferry, *172 Pa. Super. 372, 379 (1953).*

13/ Pennsylvania State Board of Pharmacy v. Cohen, *448 Pa. 189, 204 (1972).*

14/ 63 P.S. §§ 421.1 et seq.

15/ 63 P.S. § 421.15 (a) (8).

16/ State Board of Osteopathic Examiners v. Berberian, *200 Pa. Super. 533, 536 (1963).*

17/ 421 U.S. 773 (1975).

18/ 15 U.S.C. § 1.

19/ 421 U.S. at 786 n. 15.

20/ 421 U.S. at 787.

21/ Ibid. *(citations omitted).*

22/ Id. *at 788-9 n. 17.*

23/ See Gasoline Retailers Assn., Inc. v. U.S., *285 F.2d 688 (7th Cir. 1961).*

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Naming and developing an office manager—part two

Leif C. Beck, LL.B., C.P.B.C.
Vasilios J. Kalogredis, J.D.

In last month's article we wrote of the challenge and risk involved in designating and developing an office manager. The success or failure of the new manager probably depends more on the physician in final charge than on the selected person. The physician must be conscientious and perceptive in developing the office manager role, a task which can be challenging for a doctor because it is somewhat ego-threatening. He must build up a subordinate to assume much of his own authority in order to extend himself.

This month's article considers the important aspects of developing a "super-aide" into a more effective office manager.

Time and attention

An effective manager cannot devote full time and energy to regular office duties. Regular jobs should be avoided when possible: no sitting all day at the reception desk or handling all the insurance forms. The office manager develops routines and policies that enable proper handling of the jobs rather than simply performing those jobs.

The promoted super-aide may instinctively try to fill in on each crisis; this instinct for conscientiousness may, in fact, be the reason for the employe's promotion. But the office manager's success comes from developing patterns to cover the crises, not from running ragged to cover them.

Management requires thinking time: business systems and people patterns must be evaluated and modified for long-term success. An employe should never be entrusted with the responsibilities of an office manager and then deprived of the time to discharge them.

Perhaps two examples will help. In one practice survey, we encountered a full-time manager who had become so bogged down by the clerical demands of a one-year-old computer billing system that the office was in near chaos. Our advice was to delegate those demands, which did not require her level of talent, and resume attention to problems of the entire office.

In another case, a conscientious employe was spending almost 70 hours a week trying to handle regular bookkeeping chores, finish all unprepared insurance forms, and generally run the office. The practice was slipping for reasons attributable in part to its staff and systems. We urged hiring an additional employe so that the manager would have time to improve the office systems.

Freeing a super-aide from regular duties must be accomplished delicately. Other assistants can become resentful about "one of the group" being exempted from work. The reaction is understandable, for the manager may no longer have quantitative assignments (other than the vague term "to manage") and may then assign previous work to others. If the selected manager is perceptive and receives diplomatic backing from the doctor(s), the problem usually can be overcome.

Doctor's support

The office manager must have a level of authority over the staff that is in no event undercut. Any appearance that an employe can bypass the manager can be fatal to that role. Each physician must keep this requirement firmly in mind and resolve to be consistent in his reliance on the manager.

A doctor may nevertheless receive requests and suggestions directly from his staff, for the manager cannot become a means of shutting off open discussion. He may acknowledge the requests and/or suggestions with the promise that he will discuss them with the manager for their joint decision. The doctor is in charge, and if he feels strongly enough he may order the manager to handle the problem a certain way. In this way the image of managerial responsibility is maintained. To promptly decide the point in the employe's presence, however, may destroy the manager's authority and may overlook factors not presented with the employe's request.

The opposite side of the authority issue is the need to develop an open, cooperative office. Communication at and between all levels should be encouraged. A manager who attempts to stifle communication will soon lose the capability to motivate the staff. As a result, we sometimes lecture office managers to "Keep it warm and open but fight like hell if you're undercut."

Daily time with owner

Even if for only ten minutes a day, the office manager must have a chance to communicate with the physician-owner. The manager must have guidance, and the doctor must be aware of what is happening in the office. The physician must remember to "manage the manager."

Some practices meet this need by scheduling the first fifteen minutes of each morning for manager-physician discussion. He can then give any special instructions and raise his or his group's concerns. The manager can

The authors are the principal consultants of Management Consulting for Professionals, Inc., Bala Cynwyd.

describe progress on undertakings, raise problems and questions, and generally be certain that plans are understood and respected by the physician-owner. Forcing this daily exchange into the doctor's pattern can help assure effective management.

This required communication includes ongoing evaluation and criticism of the manager's performance. The manager needs such work review even more than the staff, but the higher position of responsibility often deters doctors from facing up to good and bad points. We recently worked with a surgical practice which decided to terminate the manager's employment because of deficiencies which, we feel, could have been overcome had they been discussed candidly.

Being an 'insider'

We urge physicians to include their office managers in virtually all inter-doctor business meetings. The manager should be considered an "executive" who is both privileged and responsible to participate at the decision-making level.

At the meetings, the office manager's first task should be to report on the business. This should include a presentation and discussion of the most recent financial report and the manager's concerns or recommendations regarding it. Progress on matters previously discussed should then be reported, thus holding the manager responsible that progress is in fact being made.

Physicians' business meetings are notoriously unproductive, but intelligent use of the office manager can dramatically upgrade their effectiveness. The manager should see each doctor several days in advance to determine what items he wants discussed, and prepare an agenda to be distributed for thought before the meeting. At the meetings, the manager should take notes and remind the doctors of things they agreed to handle. In this respect, the manager can help the doctors become better "doers."

Perhaps even more importantly, the manager can assume responsibility to carry out decisions made at the meetings, thus freeing the doctors for their other demands. The undertaking and its subtleties will be better understood if the manager participated in the meeting rather than being given instructions later.

Some doctors consider their practice finances so confidential that even the office manager is not privy to them. We consider this attitude extremely unwise, for there is really nothing to gain from such confidentiality. Instead, inclusion as an "insider" in financial planning and monitoring helps the manager apply economics to office decisions.

Describing the position

Fairness to the manager calls for a clear definition of responsibilities. A written job description should be developed and discussed candidly from the beginning. One practice's description was presented as Table 1 of last month's article and may be useful.

Although a lack of clarity about the manager's activities will undoubtedly exist, the exercise of quantifying them as much as possible is beneficial. As new responsibilities arise and existing duties change, the writing should be revised. While any employe's job definition should undergo constant reconsideration, the office manager's should probably be the most flexible of all.

One of the new manager's earliest tasks should be to review and republish all employes' job descriptions. The manager may have some fresh ideas of how the various assistants can work most effectively, and these ideas should be encouraged. The exercise of reviewing each person's duties, both individually and collectively, is a good way to learn about office interactions.

Success may come slowly

The doctor(s) cannot simply assume that an office will function smoothly soon after a manager's selection. It takes time for the manager to settle into the job, for desired improvements to be made, and for the staff to accept the role. The physician must be patient and alert to the manager's development.

Frequently a manager is more effective with employes recruited and hired by the manager, for they are likely to accept the role. But assistants already in their jobs when an office manager is thrust upon them may resist. The physician must again be patient, but employes who interfere with the new relationship must be replaced.

The doctor should give his highest trust and support to the manager, even at the expense of other good employes, unless and until he concludes that the manager is failing.

Designating someone as office manager is only the beginning. The physician(s) must thereafter give attention and support to helping the manager become effective, for success in the position will in large part depend on the doctors. □

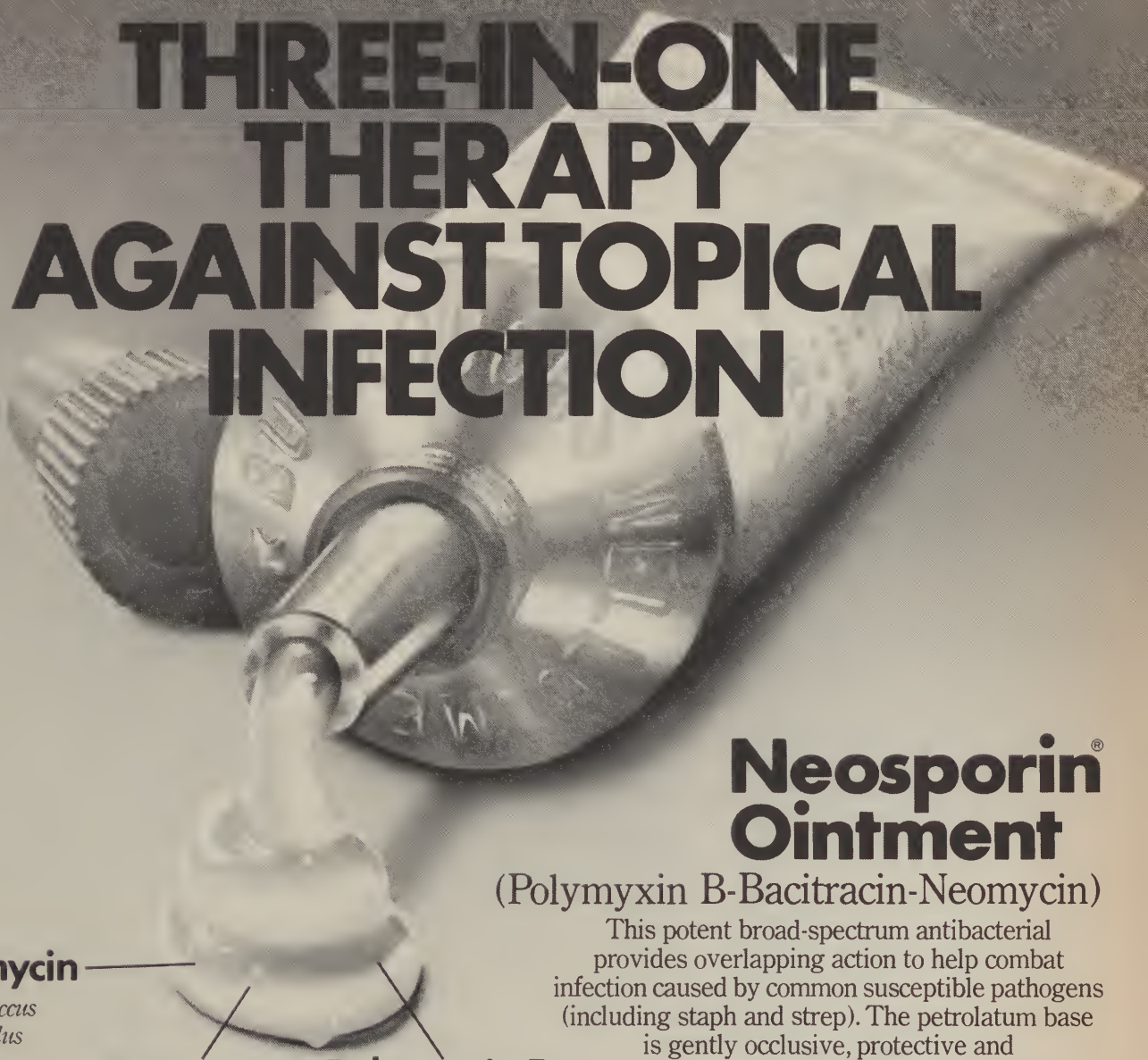
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Study and recommendations

Biliary tract disease: selection of patient and antibiotics

Philip P. Metzger, M.D.
Herbert A. Ecker, Jr., M.D.
Lewis T. Patterson, M.D., F.A.C.S.

Isolating and identifying bacteria from gallbladder bile may not help in the management of cholecystitis, but potentially invasive pathogenic organisms in the bile demand the surgeon's attention. Local or systematic contamination may occur during biliary operations and, in selected cases, antimicrobial therapy may reduce postoperative morbidity.

Our study analyzed a population of patients having biliary tract surgery. We established the characteristics which determined the risk level of particular patients having a positive bile culture. Additional information was collected on the organisms most frequently isolated from bile cultures. Antibiotic resistances of these organisms were obtained. The resistances clarified changing bacteriological patterns in our population sample and offered support for recommending appropriate antibiotic prophylaxis to reduce morbidity.

Materials

Five hundred and forty-nine consecutive biliary tract operations were analyzed retrospectively. The operations were performed from August 1974 to December 1976 at Polyclinic Medical Center, Harrisburg. Aspiration gallbladder bile cultures, obtained under sterile conditions at the time of surgery, were plated on blood agar, CNA agar, Maconkeys agar, and cooked beef broth. *In vitro* antibiotic sensitivity tests were performed on positive gallbladder bile cultures. The charts were reviewed to correlate culture results with patient population, type of surgery performed, and gallbladder pathology.

Drs. Metzger and Ecker are residents in surgery and Dr. Patterson is director of surgery at Polyclinic Medical Center, Harrisburg.

Results

Of the 549 cases analyzed, the age range was 16 to 103 years. The mean age of the population was 50.17 years and the median age was 50 years. Females comprised 432 patients, 78.7 percent of the population; and males, 117 patients, 21.3 percent of the group. Analysis of distribution according to race and sex yielded a majority (72.3 percent) of the cases as white females.

Cultures were obtained in 521 of 549 cases. Of these, 96 showed bacterial growth when cultured. Thus an overall positive culture rate of 18.4 percent was obtained. Pure cultures were found in 61 of the 96 positive cultures (63.5 percent) and mixed cultures in 35 cases (36.5 percent). The most common organism isolated in pure culture was *Escherichia coli;* other organisms found in pure cultures are listed in Table 1. Table 2 shows the relationship of age and sex to the rate of positive cultures obtained.

Using the pathological description of the gallbladder, the 521 cases cultured were divided into three groups (Table 3). Group 1 represented chronic cholecystitis; group 2 represented acute cholecystitis; and group 3 represented other conditions. The third group contained two cases of adenomyosis of the gallbladder and three cases in which no diagnostic abnormalities were found in the gallbladder specimens. The acute

TABLE 1
Pure Cultures—Five Most Common Organisms

	No. of patients	Percentage of patients
Escherichia coli	17	27.9
Staph. epidermis	14	23
Strep. viridans	11	18
Klebsiella pneumoniae	7	11.5
Strep. fecalis	4	6.6

TABLE 2
Relation of Age to Positive Bile Cultures

Age	*Males*		*Females*		*All Cases*	
20	None 0%		0/5	0%	0/5	0%
20-29	1/8	12.5%	4/71	5.6%	5/79	6.3%
30-39	2/14	14.3%	2/55	3.6%	4/69	5.8%
40-49	3/17	17.6%	6/91	6.6%	9/108	8.3%
50-59	7/35	20.0%	9/71	12.7%	16/106	15.1%
60-69	5/22	22.7%	11/55	20.0%	16/77	20.8%
70-79	8/13	61.5%	18/40	45.0%	26/33	49.0%
80-89	3/4	75.0%	13/16	81.3%	16/20	80.0%
90-103	None 0%		4/4	100%	4/4	100%
Total	29/113	25.7%	67/408	16.4%	96/521	18.4%

TABLE 3
Relation of Gallbladder Pathology to Positive Bile Cultures

	Males		*Females*		*Total*	
Group 1:						
Chronic cholecystitis	19/87	21.8%	42/340	12.4%	61/427	14.3%
Group 2:						
Acute cholecystitis	10/26	38.5%	25/63	39.7%	35/89	39.3%
Group 3:						
Other conditions	0	0%	0/5	0%	0/5	0%
Total	29/113	25.7%	67/408	16.4%	96/521	18.4%

TABLE 4
Relation of Surgical Procedure to Positive Bile Cultures

	Males		*Females*		*Total*	
Cholecystectomy	10/81	12.3%	37/316	11.7%	47/397	11.8%
Cholecystectomy with cystic duct cholangiogram	9/17	52.9%	14/64	21.9%	23/81	28.4%
Cholecystectomy with cystic duct cholangiogram and common duct exploration	5/8	62.5%	4/13	30.8%	9/21	42.9%
Cholecystectomy with common duct exploration	1/2	50%	7/9	77.7%	8/11	72.7%
Cholecystectomy with cystic duct cholangiogram and common duct exploration and biliary bypass procedure	3/3	100%	1/1	100%	4/4	100%
Cholecystectomy with previous cholecystostomy	0/0	0%	3/4	75%	3/4	75%
Cholecystostomy	0/0	0%	1/1	100%	1/1	100%
Cholecystectomy with cystic duct cholangiogram with common duct exploration and sphincteroplasty	1/2	50%	0/0	0%	1/2	50%
Total	29/113	25.7%	67/408	16.4%	96/521	18.4%

TABLE 5
***In Vitro* Resistances of Organisms Isolated**

Drugs	Percent resistance of five most common organisms and all organisms					
	E. coli	*Kleb. pneum.*	*Strep. virid.*	*Staph. epid.*	*Strep. fecalis*	*All organisms*
Ampicillin	12.8%	85%	0%	66.7%	14.3%	27.8%
Chloramphenicol	0%	0%	0%	0%	14.3%	6.2%
Gentamicin	2.6%	0%	0%	-	21.4%	2.5%
Cephalosporin	15.4%	0%	5.9%	0%	92.6%	20.4%
Streptomycin	10.3%	5%	-	-	-	6.2%
Tetracycline	12.8%	10%	11.8%	26.7%	42.9%	16.7%
Penicillin	-	-	0%	60%	57.1%	11.7%
Methicillin	-	-	11.8%	6.7%	92.9%	10.5%
Carbenicillin	5.1%	100%	-	-	-	15.4%

cholecystitis group showed a higher positive culture rate than the chronic cholecystitis group. The male population in the chronic cholecystitis group had a higher positive culture rate than did the female population.

The type of surgical procedure undertaken was correlated with sex and rate of positive cultures. Table 4 shows that as common duct exploration, biliary bypass, sphincteroplasty, or cholecystostomy were performed the rate of positive cultures increased.

In our study, 108 cases had operative cystic duct cholangiography. Twenty-seven (25 percent) of these cholangiograms suggested the need for common duct explorations. Seventeen (63 percent) of the 27 common duct explorations resulted in positive correlation with the cholangiographic findings.

Three hundred and ninety-four cases were analyzed for in-hospital wound infections. Seventeen wound infections were found in this group.

Routine *in vitro* antibiotic sensitivity tests were taken on all 96 cases of positive bile cultures. Table 5 summarizes the results of these tests.

Discussion

During the past half century, reports have been published concerning the bacteriology of the biliary tract.[1-6] Most cholecystitis do not have a clearly bacterial etiology.[7] Csendes *et al.*[8] have shown that normal gallbladders, as assessed by oral cholecystography and intra-operative palpation, have sterile cultures when gallbladder bile is bacteriologically analyzed.

In their review article on cholecystitis, Magner and Hutcheson[9] show that positive bile cultures were obtained in 34.7 percent of cases when gallbladder bile was cultured and in 63.4 percent when the gallbladder wall was cultured. This was confirmed by Andrews and Henry,[10] who found bacteria twice as frequently in the gallbladder wall cultures. They explained that lymphoid tissue in and around the wall of the gallbladder, especially near the duct, acted as a filter, and concentrated more bacteria in the gallbladder wall than in bile.

Goswitz,[11] who took bile cultures from patients undergoing biliary tract surgery, obtained a positive culture

rate of 15 percent of his 118 cases. Our study showed an overall positive culture rate of 18.4 percent from gallbladder bile aspiration cultures.

The three most common organisms encountered in our study were *Escherichia coli, Klebsiella pneumoniae,* and *Strep. viridans.* This correlates well with previous studies.[1] Anderson and Priestly,[12] for example, found pure cultures in 56 percent of their bile cultures. This compares with our pure culture rate of 63.5 percent.

Determining which patients have a higher risk of positive bile cultures seems advantageous. Factors increasing the risk of positive biliary cultures are well documented. They are: increasing age; acute inflammation; biliary tract obstruction and jaundice; and clinically active sepsis.

Mason[5] reported that more than half his patients over the age of 60 had positive bile cultures. Pyrtek and Bartus[4] showed that at least 60 percent of their patients had positive cultures at age 69 or greater. Our data correlate with these studies; they show that almost half our patients had positive cultures at age 70 or greater.

Our study shows an approximate three-fold increase in positive bile cultures in patients with acute inflammation of the gallbladder. This is in agreement with Ram and Gharavi,[6] who reported that 23.5 percent of their patients with chronic cholecystitis had positive cultures and 65 percent of the acute cholecystitis group had positive cultures.

Edlund and his associates[13] explained that with common duct stones positive cultures were obtained in as many as 90 percent of their patients. Flemma *et al.*[3] showed that 64 percent of their patients with partial common duct obstruction due to stricture, choledocholithiasis, and bile duct carcinoma had positive bile cultures. Our study reaffirms this finding. We found that when surgical procedures were undertaken for common duct obstruction, the incidence of positive bile cultures was 50 percent or greater.

Most authors agree that when clinically active sepsis is suspected, antibiotics should be administered. Mulholland *et al.*[14] state "Antibiotics may be helpful if a febrile course is thought to be due to associated suppurative cholangitis or to liver abscess."

Use of antibiotics

With these criteria in mind, it is logical to discuss which antibiotics might be employed in specific cases of biliary tract surgery. Robson *et al.*[15] reported that the chief source of wound infection in biliary tract surgery is endogenous. They suggest that a quantitative, as well as a qualitative, relationship exists between bacteria isolated from the biliary tract and the ensuing wound infection rate.

Our in-hospital wound infection rate was 4.3 percent and the wound and bile cultures correlated in 35 percent of the cases. Bernard and Cole[16] have shown that these endogenous induced infections can be reduced significantly by administering antimicrobial agents immediately before, during, and for a short time after, a surgical procedure.

In vitro antibiotic sensitivity testing offers some indication for appropriate antibiotic selection, but an antibiotic can only be effective when it reaches the biliary tract in high concentrations. High concentration levels of tetracycline and rifampicin[17] and cephalothin[18] have been found in bile; ampicillin poorly penetrates the biliary tract.[19] Mason recommends treatment with penicillin plus chloramphenicol or tetracycline in selected cases of biliary tract surgery. Pyrtek and Bartus recommend penicillin in combination with streptomycin or chloramphenicol or more recently cephalothin for biliary tract prophylaxis.

Our study suggests that chloramphenicol or a combination of a cephalosporin and an aminoglycoside are the prophylactic antibiotics of choice in higher risk patients who are likely to have positive biliary cultures. Such treatment may prevent postoperative morbidity. We also suggest that, in addition to aspiration gallbladder bile cultures, taking a culture of the gallbladder wall will increase the yield of positive cultures.

Conclusion

A retrospective analysis of 549 consecutive cases of biliary tract surgery determined the organisms most often involved in biliary tract infection and the patients most likely to have infected bile. Aspiration gallbladder bile cultures obtained at the time of surgery indicated that elderly patients, patients with acute cholecystitis, cases of biliary tract obstruction, and patients in whom clinically active sepsis is present stand at a high risk of having infected bile. Prophylactic antibiotics should be administered to this group of patients, and we recommend chloramphenicol or a combination of a cephalosporin and an aminoglycoside to reduce postoperative morbidity. □

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*R. B. Greenblatt, M.D.; R. Witherington, M.D.,; I. B. Sipahioglu, M.D.; Hormones for Improved Sexuality in the Male and Female Climacteric. **Drug Therapy,** Sept. 1976.

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Medical education programs evolve in Pennsylvania

Wilbur W. Oaks, M.D.
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Physician shortage has become a chronic problem in rural Pennsylvania. The authors describe a medical education program aimed toward a solution.

In the fall of 1976, the Carnegie Foundation published a report commissioned by the President entitled "Progress and Problems in Medical and Dental Education." The report cited the irregular distribution of health manpower and the insufficient number of primary care physicians as the number one health problem facing America.

More than five years before, educators at Hahnemann Medical College and Hospital in Philadelphia and Wilkes College in Wilkes-Barre were directing their attention to the same problem. In northeastern Pennsylvania, family doctor populations were dwindling. Doctors who remained were nearing retirement. (In 1970, 52 percent of all physicians in northeastern Pennsylvania were over 55.) Unless something could be done soon, health care delivery in northeastern Pennsylvania would break down.

Incentive programs to relocate doctors from urban areas to areas of need in the country weren't working. The clinic-health care center was only a partial answer, unless doctors staffing the clinics became sufficiently committed to the area to stay past their short-term contract and add some continuity to the health care—and they weren't.

"Outreach" program

Viewing the growing problem, academicians and clinicians went to work, hammering out the details of a plan for a cooperative outreach program for medical education which would recruit bright young students from areas of need, train them, and cycle them back into northeastern Pennsylvania as family doctors. The plan was designed to maintain and strengthen ties to the home area throughout the medical education program.

The Wilkes-Hahnemann program, which was to become the first of the medical development/Pennsylvania (MD/PA) programs, incorporates an accelerated undergraduate program (two years plus two summers), three full years in Philadelphia at Hahnemann Medical College on track with all other medical students, and a unique fourth year of medical school which takes place at clinical facilities in the outreach area. Simultaneous with the plan's development was the expansion of family practice residency programs in the outreach community.

In 1972, the first MD/PA Wilkes-Hahnemann class entered phase I at Wilkes College. Lehigh University in Bethlehem soon joined the MD/PA program arena along with Gannon College in Erie and Widener College in Chester. The Bethlehem-Easton, Erie, and Chester areas share relevant characteristics with the Wilkes-Barre/Scranton area. All are relatively high density population areas surrounded by medically underserved, sparse populations. All have excellent clinical facilities which can be enlisted for the fourth year outreach portion of the medical college education.

The authors are associated with Hahnemann Medical College in Philadelphia. Dr. Oaks is chairman of the department of medicine and associate dean of extension health education and training. Dr. Pairent is associate dean in the office of medical education. Dr. Turchetti is associate dean of the Wilkes-Hahnemann program. Ms. Saylor is director of program development and communications.

It is expected that some of the 785 students now in phases I, II, and III of the program will "fall by the city wayside" and that others will choose to live in other regions, drawn by wives or other considerations. But MD/PA programs will be an overwhelming success if even a majority of the young doctors return to practice family medicine, because before these MD/PA programs were initiated there were no replacements for the steady decline of family doctors in already underserved regions.

MD/PA programs won't solve distribution problems overnight. Even with the accelerated undergraduate phase I, it still takes between seven and nine years for a young doctor to be ready to practice on his own. Unlike the rural health centers with "temporary" contract doctors cycling through, however, MD/PA is designed to steadily provide "permanent" solutions to the distribution problem. As one family doctor nearing retirement age in Kingston remarked, "We need doctors who want to come back and live here, work here, and become part of the community."

Involvement with the local medical community—including family practitioners, specialists, and administrators of area hospitals—is vital to the MD/PA outreach concept.

Seminars and follow-up studies are conducted by Hahnemann faculty for clinicians and preceptors participating in the unique third phase of outreach medical college. Students are carefully matched with primary care physicians and specialists at outreach

hospitals. The MD/PA philosophy is to introduce them to the area medical community, an early integration into a system which will serve as a back-up once they are ready to practice in the outlying regions.

Supporting the concept of continuous integration into the area medical community is the expansion of existing residency programs and the development of new residency programs in the medical community of the outreach area. Statistics indicate that, along with "place of rearing," place of residency is a prime factor in determining where young doctors decide to practice. Thus, the development of residencies within the outreach area becomes essential for the success of the MD/PA programs.

As the programs are planned and implemented, an interesting phenomenon occurs. The medical community, formerly composed of separate, competitive hospitals, clinics and individual doctors, works together in a common program and moves toward becoming an area health center that provides new programs and contacts for consultation, cooperation, and continuing education.

Communications network

The MD/PA goal for health care delivery in the outreach areas is to reinforce and create, where necessary, open lines of communication between the urban-based medical center, the growing "area health center" complex, and individual family practitioners within the area. By establishing these medical "link-ups," new and established doctors are tied together in a dynamic support system. This prevents the feeling of "isolation from the modern medical community," which is a common problem for many young family practitioners in sparsely populated areas.

This support system is facilitated in the MD/PA programs through an interactive telecommunications network which links Hahnemann Medical College, the outreach undergraduate schools, and clinical facilities.

The network was initially conceived as an educational tool for phase III, or the fourth year of medical school, occurring in the outreach areas. The interactive telecommunications system makes it possible for students in "mini-preceptorships" at the various hospitals to go, at specified times, to an interactive studio located in each of the hospitals where they attend "live" discussions and demonstrations occurring at Hahnemann under the guidance of the medical college faculty. The interactive system also allows students in the outreach areas to bring a patient to an outreach hospital studio, discuss symptoms, and conduct an examination with a specialist in the Hahnemann studio observing and commenting.

The MD/PA network has other uses that are equally important. Continuing education courses for physicians working in the outreach areas will help them keep in touch with the main stream medical community. Other established physicians already practicing in the area can also take advantage of these courses. In addition, courses for allied health professionals are proposed at affiliated undergraduate colleges and universities.

As an outreach arm for emergency and consultative health care delivery, the network is unparalleled. Rather than rushing a patient hundreds of miles to super-specialists at urban-based hospitals, consultations at outreach hospitals can take place within minutes. Data from EKGs, x-rays, phono-echos, and ausculatory findings can be transmitted through the network to be interpreted by experts at the urban-based hospitals.

The scope of the MD/PA telecommunications network grew to include a general consideration of area health care needs and delivery systems for this health care. It became obvious as more undergraduate schools joined with Hahnemann to develop MD/PA programs that Hahnemann was directing its medical education program toward serving a definable statewide need. We determined numbers of students in individual MD/PA programs based on the needs and capabilities of each region. Suddenly, we had entered an era of "planned, goal-oriented education." This was not a government directive.

Cost vs. benefit

Taken in historical perspective it is impossible to pinpoint the moment of awareness that we were actively analyzing statewide health care needs, directing our educational structure to meet those needs, and devoting half the space in our medical college to MD/PA students. But the fact is that such a philosophy is crucial in a time of spiraling medical education and health care costs. At all levels of our government the "cost-benefit ratio" is being examined. Is the cost of doing or producing something warranted by the benefit?

If we can say that the medical education system is directing young peo-



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ple toward filling necessary jobs in health care delivery, then we can say we are responsibly serving our educational role. And if the system of education upgrades the local health care delivery and creates cooperating area health centers, then we fill a social as well as educational role. This practice is common for a teaching hospital, but MD/PA goes a step beyond by creating "teaching communities" involved in health care delivery.

The initial funding for the Wilkes-Hahnemann prototype came through substantial grants from NIH and HEW for a six-year period. Funding ended in 1977. Another source of support has come from corporate grants. The Kellogg Foundation has funded a family practice residency program in Wilkes-Barre which will provide residency "slots" for MD/PA doctors. A Gulf Oil Foundation grant funded construction of the central telecommunications studio at Hahnemann in Philadelphia.

The planning and establishment of the subsequent MD/PA programs has been fiscally supported by the institutions involved. Funds generally allocated for other operations and programs have been channeled into MD/PA because all of us in the programs feel a deep sense of commitment to MD/PA. We view MD/PA programs not only as exciting educational offerings to prospective students, but as a viable answer to what the recent Carnegie Commission report to the President stipulates as the number one health care problem facing America today—the distribution of physicians.

As we widen our MD/PA perspective to encompass the Commonwealth, we realize we cannot continue to sustain and expand the programs, stretching our resources and those of the outreach schools, without additional funds. Because it is the role of our state government to fund education and health care programs, we are looking to the Pennsylvania legislature for support.

MD/PA was initiated independently. If it is to succeed on a large scale and make a significant contribution to redistributing physicians to all areas, it is imperative that the Commonwealth reach out with vital dollars to assure its continuance. □

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Edward H. Achorn, M. Adm., C.P.A.

If you already have a pension plan for your professional corporation, you may be missing the benefits of a profit sharing plan. If you have a profit sharing plan, you may be overlooking its potential.

Many physicians incorporate their medical practices because they've heard about the benefits of a retirement plan in a professional corporation. Typically they call their accountants, attorneys, and bank trust officers. Often they focus solely on the number of dollars they'll save now in income taxes and the amount of money available when they retire. Because the doctor asks for a "retirement" plan, his advisors may suggest a corporate pension plan without reviewing the possibilities of supplementing or replacing it with a profit sharing plan. This article will examine the good and bad aspects of this "other" retirement plan.

Profit sharing plans

There are two types of pension plans. The defined benefit plan, which bases contributions on the ages of the physician and his staff, their life expectancies, and the income required to be paid at retirement, is one variety. Also available is the defined contribution pension plan. Annual contributions to this plan are based on a percentage of the salaries and wages of the physician and his employes.

As its name implies, the contributions to a profit sharing plan may be based on a percentage of the corporation's profits. This method is rarely used in a professional corporation because the corporation's income is usually negligible and most of the revenue is paid to the physician and his staff as salaries.

A professional corporation will invariably determine annual contributions to a profit sharing plan as a percentage of salaries. The maximum contribution by the corporation is 15 percent of any employe's salary, including the physician's. The maximum contribution of 15 percent of salary is limited to $28,175 per employe. This maximum will be increased by the IRS for inflation.

In addition to the professional corporation's contributions to the profit sharing plan, which are fully deductible by the corporation and not taxed to the individual, a profit sharing plan can be arranged so that voluntary employe contributions of up to 10 percent of the individual's compensation may also be made. While the contributions by the employe are not tax deductible, the earnings on those contributions can accumulate tax free. Another limit to remember is that the professional corporation's contribution plus the employe's voluntary contribution plus the employe's allocated share of profit sharing assets forfeited by a terminated employe must not exceed the lesser of 25 percent of the employe's compensation or $28,175. If a physician is concerned about locking himself into a contribution schedule for a profit sharing plan at a fixed percentage of compensation, provisions can be inserted into a profit sharing plan giving him flexibility and relieving him of that potential burden.

A variable contribution percentage of compensation for a profit sharing plan is a particularly attractive feature to young professionals with incorporated practices. This feature permits the board of directors of the professional corporation to change annually the percentage contribution to the profit sharing plan. This may be useful if a professional has large personal expenses in a year and does not want to be forced into making high payments to the profit sharing plan.

Mr. DeMuth is a professional management consultant and assistant professor of accounting and finance at The Pennsylvania State University's Capitol Campus, Middletown. Mr. Achorn is president of Electronic Data Associates, Inc., Lemoyne, and assistant professor of accounting and management at Capitol Campus.

Benefits of profit sharing

While the primary purpose of a pension plan is to provide for benefits during retirement, retirement benefits are only one of several options available to profit sharing plan participants. This aspect of a profit sharing plan makes it more flexible than a pension plan. It is especially appealing to the physician who is faced with a home down payment or providing for his children's education.

Instead of receiving profit sharing plan distributions upon retirement, it is possible for the physician and his employes to begin receiving them after a specified number of years. Also it is possible for a professional corporation employe to receive benefits in the event of "hardship." Hardship includes disability, illness, and layoff. The administrative committee of the profit sharing plan typically has the right to determine if an employe is

entitled to hardship benefits, which should be defined in terms of an objective standard.

It is also possible for a physician and his employes to continue to work after a normal retirement age and continue to have contributions to the profit sharing plan set aside for them. They need not receive benefits until they stop working and actually retire. In the event of an employe's death, his beneficiary is entitled to the benefits he would have received. For an expanded discussion of pension and profit sharing plan benefit taxation upon the physician's death, see "Planning means heirs share estate, not government" (PENNSYLVANIA MEDICINE, December 1977).

Distribution of money accumulated in a profit sharing plan also may take place after a fixed number of years of participation in the plan or upon the attainment of a stated age. While the money set aside for the profit sharing plan and the earnings while that money accumulates in the plan are not taxed to the employe, the money is taxed when distributed to the physician or his employes.

In the best of all worlds the physician could have the use of his money and defer paying taxes on it. Before dismissing this as wishful thinking, the physician should note this potential provision in a profit sharing plan agreement. It is possible to obtain a loan from your profit sharing plan. That's right, a physician can borrow the money and it won't be taxed to him. To qualify for a profit sharing plan loan, the plan must have the following provisions for loans:

1. It must be available to all participants or beneficiaries on an equivalent basis.
2. It is not made to highly compensated employes, officers, or shareholders in an amount greater than that available to other employes.
3. It must be made in accordance with specific provisions set forth in the profit sharing plan.
4. The loan must bear a reasonable rate of interest.
5. The loan must be adequately secured.[1]

The provisions state that physicians may not make loans available only to themselves and exclude other employes who participate in the profit sharing plan. Loans are adequately secured if the borrower uses as collateral the money which has accumulated for him and to which he is entitled in the profit sharing plan. It is possible for the loan to exceed the amount of his vested benefits, but it must be secured adequately by other property. The borrower also must pay a reasonable rate of interest. Any interest paid is tax deductible when computing federal income tax.

Caution: Any understanding, written or otherwise, that the loan does not require repayment will cause the loan to be considered a distribution, which is taxed at the time the money is received. The authors recommend that an interest rate or a formula for determining the interest rate be included in the profit sharing plan agreement and provisions for repayment of the loan be stated. It also may be wise to include a provision not permitting additional loans to be received within a specified time period.

Vesting

An employe is not necessarily entitled to everything that is set aside for him in the profit sharing plan. Profit sharing plans have arrangements for vesting as do pension plans. Vesting provisions determine the portion of the funds set aside for an employe to which he is entitled at a point in time. For example, if an employe has $10,000 of accumulated contributions and earnings in a profit sharing plan and is 50 percent vested, he is entitled to receive $5,000 if he terminates.

The IRS requires that profit sharing plan participants become fully vested in accordance with one of three vesting schedules as a minimum. If the professional corporation uses *cliff* vesting, the plan participant must be 100 percent vested after ten years of service; *graded* vesting requires that an employe is 25 percent vested after 5 years of service, receives an additional 5 percent vesting per year in the sixth through tenth years of service, and an additional 10 percent a year in the eleventh through the fifteenth year of service, so the employe is fully vested after 15 years; the *rule of 45* vesting method is determined by adding the employe's age to his years of service with the professional corporation. If that is greater than or equal to 45 and the employe has 5 years of service, the employe is 50 percent vested. An employe with 5 years of service must be 50 percent vested and must receive an additional 10 percent per year until he is fully vested. Any employe with ten years of service must be 50 percent vested with a 10 percent increase in each succeeding year. Of course any liberal modifications of either of these three schedules would be accepted by the IRS. Table I illustrates these schedules.

TABLE I
Vesting Schedules

Years of service	Percentage of Benefits Vested: Cliff vesting	Graded vesting	Rule of 45 vesting*
1	0%	0%	0%
2	0	0	0
3	0	0	0
4	0	0	0
5	0	25	50
6	0	30	60
7	0	35	70
8	0	40	80
9	0	45	90
10	100	50	100
11	100	60	100
12	100	70	100
13	100	80	100
14	100	90	100
15	100	100	100

*If age + years of service ≥ 45.

[1]*Section 4975 (d), Internal Revenue Code of 1954.*

The purpose of vesting is to reward the long-term employe and give no benefit or a reduced benefit to the transient or short-term employe. The professional corporation may exclude those employes who are not yet 25 years old or have not completed one year of service in which they worked 1,000 hours or more. It is *not* possible to exclude elderly employes from the plan because of their age.

If the professional corporation wishes to provide a profit sharing plan but wants to limit its contributions, it is possible to "integrate" the plan with social security. Essentially, nothing is contributed toward employe earnings less than the social security base, which is $17,700 in 1978; contributions on earnings in excess of that amount are generally limited to 7 percent. The rules affecting social security integration can become very complex if the professional corporation is involved with anything other than a straightforward plan. It is especially important to get competent advice.

It is also possible for the professional corporation to permit or require employes to contribute to the profit sharing plan up to 10 percent of compensation. This provision permits the physician and his employes to set aside money which has been taxed to them individually, but on which earnings will not be taxed until they are removed from the profit sharing plan. The vesting provisions do not apply to employe contributions. If an employe terminates he is entitled to his contributions plus the earnings on those contributions, even if he has no vesting in the employer's contributions.

In addition to the features discussed, it is also possible to have each participant in the profit sharing plan determine the investment vehicles for his money. This "ear-marking" allows the physician and his employes to control the destiny of their own profit sharing plan contributions.

The profit sharing plan permits flexibility in contributions and distributions which pension plans do not have. It is possible for a professional corporation to have both a pension and a profit sharing plan. If your professional corporation is considering a "retirement" plan, explore the "other" retirement plan—profit sharing. □

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• **Sol N. Bers,** York; Jefferson Medical College, 1939; age 64; died March 2, 1978. Dr. Bers was a pediatrician in York for 27 years.

• **James Butcher,** Wayne; University of Pennsylvania School of Medicine, 1939; age 64; died February 14, 1978.

• **Edmund D. Clements,** Coraopolis; University of Pittsburgh School of Medicine, 1934; age 66; died March 28, 1978.

• **Carson S. Dimling,** Pittsburgh; University of Pittsburgh School of Medicine, 1931; age 73; died March 26, 1978. Dr. Dimling was a former chief of the eye, ear, and nose department at the Veterans Administration Hospital, Oakland, and a past president of the Pittsburgh Otological Society.

• **Henry K. Heller,** Bethlehem; Harvard Medical School, 1941; age 63; died February 21, 1978. Dr. Heller was a former staff president of Muhlenberg Medical Center. In 1967 he served a tour of duty as part of the Volunteer Physicians for Vietnam program sponsored by the American Medical Association. He retired from medical practice in January 1977 after 28 years of service.

• **Edwin J. Kamons,** Uniontown; University of Virginia School of Medicine, 1945; age 57; died February 26, 1978. Dr. Kamons had practiced in Uniontown for 27 years.

• **Harold O. Kamons,** Markleysburg; Medical College of Virginia, 1949; age 53; died February 3, 1978. Dr. Kamons had served on the staffs of Uniontown and Meyersdale hospitals and had practiced in Markleysburg for 25 years.

• **Alexander Koppel,** Philadelphia; Jefferson Medical College, 1928; age 72; died January 18, 1978. Dr. Koppel had a general practice in Philadelphia for 48 years.

• **Gabriel M. Lizak,** Pottsville; Georgetown University School of Medicine, 1949; age 52; died April 2, 1978. Dr. Lizak, who had practiced general medicine in Pottsville for 25 years, served as the president of the Schuylkill County Medical Society at the time of his death.

• **Francis N. Mangold,** Pittsburgh; University of Pittsburgh School of Medicine, 1935; age 69; died February 13, 1978. He had practiced obstetrics and gynecology in Pittsburgh for 43 years and had been an instructor in obstetrics and gynecology at Pitt from 1937 to 1940.

• **John F. Maurer,** Greensburg; University of Pittsburgh School of Medicine, 1930; age 72; died February 18, 1978. Dr. Maurer was chief radiologist at Westmoreland Hospital for 25 years. He founded the hospital's radiology school and was a past president of the Pennsylvania Radiological Society.

• **Kerwin M. Marcks,** Wescosville; Jefferson Medical College, 1930; age 72; died March 3, 1978. Dr. Marcks had been head of the plastic and reconstructive surgery department at Allentown Hospital from 1938 to 1970. He was past president of the Lehigh County Medical Society and an honorary director at St. Luke's, Allentown, and Sacred Heart hospitals.

• **John P. Nilson,** Pittsburgh; Johns Hopkins University School of Medicine, 1970; age 33; died December 28, 1977.

• **Frederick R. Perfect,** Robesonia; University of Toronto School of Medicine, 1922; age 80; died February 28, 1978. Dr. Perfect had been chief of otolaryngology at Community General Hospital, Reading. He was a charter member of the Reading Ear, Nose, and Throat Society and the Pennsylvania Academy of Ophthalmology and Otolaryngology. In 1972 Dr. Perfect was honored by the Berks County Medical Society for 50 years of service.

• **Thomas W. Richards,** Lansdale; Hahnemann Medical College, 1947; age 57; died February 13, 1978. Dr. Richards was medical director of Menley and James, a subsidiary of the SmithKline Corporation, Philadelphia.

• **J. Shepard Smith,** Philadelphia; Howard University School of Medicine, 1931; age 74; died February 14, 1978. Dr. Smith had practiced ophthalmology in Philadelphia for 30 years. He had served as chief of ophthalmology at Mercy Catholic Medical Center and was on the staffs of St. Luke's and Children's Medical Center and Sidney Hillman Medical Center.

• **James W. Smith,** Beaver Falls; Jefferson Medical College, 1924; age 78; died March 25, 1978. Dr. Smith had practiced medicine for 52 years and upon retirement in 1972 became medical director at Babcock and Wilcox Company. In 1977 he was honored for serving 50 years on the medical staff of the Medical Center of Beaver County.

• **Wayne D. Stettler,** Hershey; Boston University School of Medicine, 1925; age 79; died March 13, 1978. Dr. Stettler had practiced medicine in Hershey for 40 years.

• **Sidney M. Wolfe,** Philadelphia; Jefferson Medical College, 1947; age 55; died March 2, 1978. Dr. Wolfe, an internist and endocrinologist, was an assistant clinical professor at Temple University School of Medicine and a former assistant professor at Jefferson Medical College. He served on the staffs of Jefferson, Rolling Hill, and Germantown hospitals and Albert Einstein Medical Center.

• **Anna E. V. Ziegler,** Downingtown; Hahnemann Medical College, 1948; age 59; died February 25, 1978.

Kendall A. Elsom, Haverford; University of Pennsylvania School of Medicine, 1927; age 73; died April 3, 1978. Dr. Elsom was a former medical director of the Scott Paper Company and professor emeritus of clinical medicine at the Hospital of the University of Pennsylvania. He was a founder and first director of the hospital's diagnostic clinic and had served also as associate chief of the department of medicine.

Nathan Epstein, Drexel Hill; Hahnemann Medical College, 1945; age 59; died February 20, 1978. Dr. Epstein was chief of pediatrics at Delaware County Memorial and Haverford hospitals.

Ivan C. Landes, Fairview Village; Jefferson Medical College, 1957; age 58; died February 13, 1978. He had practiced medicine in the area for 19 years and was a staff member of Montgomery Hospital.

John R. McNeill, Collinsville; Hahnemann Medical College, 1944; age 58; died February 22, 1978. Dr. McNeill had practiced internal medicine in Erie for 28 years.

James M. Troll, Sewickley; St. Louis University School of Medicine, 1936; age 68; died February 25, 1978. Dr. Troll was a member of the medical staff at Sewickley Valley Hospital and practiced medicine in Ambridge.

Before prescribing, please consult complete product information, a summary of which follows:

The effectiveness of Valium (diazepam) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindications: Tablets in children under 6 months of age; known hypersensitivity; acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: As with most CNS-acting drugs, caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Withdrawal symptoms (similar to those with barbiturates, alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal/muscle cramps, vomiting, sweating). Keep addiction-prone individuals (drug addicts or alcoholics) under careful surveillance because of predisposition to habituation/dependence.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations, as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

ORAL: Advise patients against simultaneous ingestion of alcohol and other CNS depressants.

Not of value in treatment of psychotic patients; should not be employed in lieu of appropriate treatment. When using oral form adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increase in dosage of standard anticonvulsant medication; abrupt withdrawal in such cases may be associated with temporary increase in frequency and/or severity of seizures.

INJECTABLE: *To reduce the possibility of venous thrombosis, phlebitis, local irritation, swelling, and, rarely, vascular impairment when used I.V.: inject slowly, taking at least one minute for each 5 mg (1 ml) given; do not use small veins,* i.e., *dorsum of hand or wrist; use extreme care to avoid intra-arterial administration or extravasation. Do not mix or dilute Valium with other solutions or drugs in syringe or infusion flask. If it is not feasible to administer Valium directly I.V., it may be injected slowly through the infusion tubing as close as possible to the vein insertion.*

Administer with extreme care to elderly, very ill, those with limited pulmonary reserve because of possibility of apnea and/or cardiac arrest; concomitant use of barbiturates, alcohol or other CNS depressants increases depression with increased risk of apnea; have resuscitative facilities available. When used with narcotic analgesic eliminate or reduce narcotic dosage at least 1/3, administer in small increments. Should not be administered to patients in shock, coma, acute alcoholic intoxication with depression of vital signs.

Has precipitated tonic status epilepticus in patients treated for petit mal status or petit mal variant status.

Withdrawal symptoms (similar to those with barbiturates, alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal/muscle cramps, vomiting, sweating). Keep addiction-prone individuals under careful surveillance because of predisposition to habituation/dependence. Not recommended for OB use.

Efficacy/safety not established in neonates (age 30 days or less); prolonged CNS depression observed. In children, give slowly (up to 0.25 mg/kg over 3 minutes) to avoid apnea or prolonged somnolence; can be repeated after 15 to 30 minutes. If no relief after third administration, appropriate adjunctive therapy is recommended.

Precautions: If combined with other psychotropics or anticonvulsants, carefully consider individual pharmacologic effects—particularly with known compounds which may potentiate action of Valium (diazepam), *i.e.*, phenothiazines, narcotics, barbiturates, MAO inhibitors and antidepressants. Protective measures indicated in highly anxious patients with accompanying depression who may have suicidal tendencies. Observe usual precautions in impaired hepatic function; avoid accumulation in patients with compromised kidney function. Limit oral dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation (initially 2 to 2½ mg once or twice daily, increasing gradually as needed or tolerated).

INJECTABLE: Although promptly controlled, seizures may return; readminister if necessary; not recommended for long-term maintenance therapy. Laryngospasm/increased cough reflex are possible during peroral endoscopic procedures; use topical anesthetic, have necessary countermeasures available. Hypotension or muscular weakness possible, particularly when used with narcotics, barbiturates or alcohol. Use lower doses (2 to 5 mg) for elderly/debilitated.

Adverse Reactions: Side effects most commonly reported were drowsiness, fatigue, ataxia. Infrequently encountered were confusion, constipation, depression, diplopia, dysarthria, headache, hypotension, incontinence, jaundice, changes in libido, nausea, changes in salivation, skin rash, slurred speech, tremor, urinary retention, vertigo, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances and stimulation have been reported; should these occur, discontinue drug

Because of isolated reports of neutropenia and jaundice, periodic blood counts, liver function tests advisable during long-term therapy. Minor changes in EEG patterns, usually low-voltage fast activity, have been observed in patients during and after Valium (diazepam) therapy and are of no known significance.

INJECTABLE: Venous thrombosis/phlebitis at injection site, hypoactivity, syncope, bradycardia, cardiovascular collapse, nystagmus, urticaria, hiccups, neutropenia.

In peroral endoscopic procedures, coughing, depressed respiration, dyspnea, hyperventilation, laryngospasm/pain in throat or chest have been reported.

Management of Overdosage: Manifestations include somnolence, confusion, coma, diminished reflexes. Monitor respiration, pulse, blood pressure; employ general supportive measures, I.V. fluids, adequate airway. Use levarterenol or metaraminol for hypotension, caffeine and sodium benzoate for CNS-depressive effects. Dialysis is of limited value.

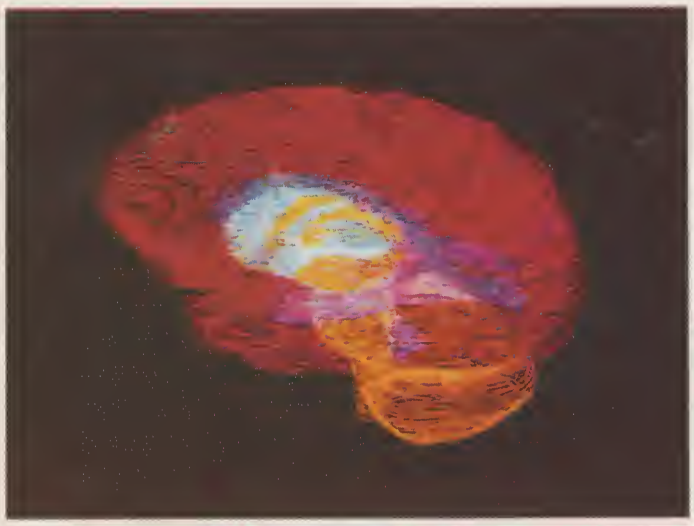
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Pennsylvania Medicine

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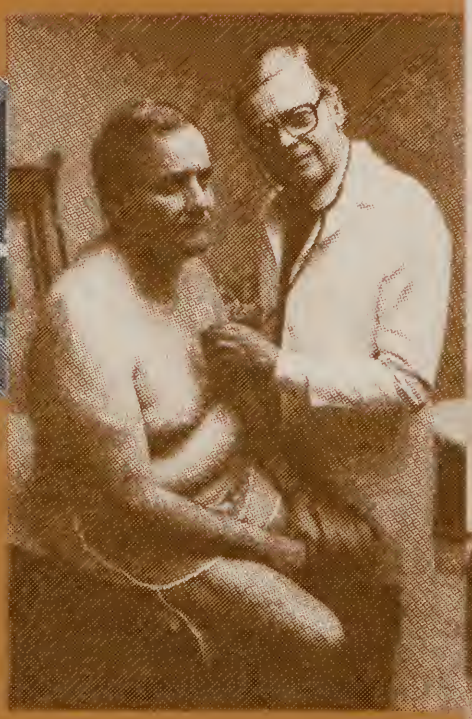
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Indications: Relief of anxiety and tension occurring alone or accompanying various disease states. Efficacy beyond four months not established by systematic clinical studies. Periodic reassessment of therapy recommended.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Warn patients that mental and/or physical abilities required for tasks such as driving or operating machinery may be impaired, as may be mental alertness in children, and that concomitant use with alcohol or CNS depressants may have an additive effect. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral–Adults:* Mild and moderate anxiety and tension, 5 or 10 mg *t.i.d.* or *q.i.d.*; severe states, 20 or 25 mg *t.i.d.* or *q.i.d.* *Geriatric patients:* 5 mg *b.i.d.* to *q.i.d.* (See Precautions.)

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AMA GRANTED COURT ORDER IN NAME DISCLOSURE SUIT

The American Medical Association was granted a temporary restraining order June 5 in its suit against Health, Education, and Welfare Secretary Joseph Califano. The class action suit seeks to restrain HEW from publicly disclosing the names of physicians and the payments they received from medicare. The AMA contends that the proposed disclosure of such information by Secretary Califano constitutes an abuse of discretion and violates the Privacy Act of 1974 and other applicable statutes and regulations. The AMA also filed a petition June 8 to intervene in a similar suit brought by the Florida Medical Association.

AMA QUESTIONS FTC RULE PREEMPTING STANDARDS

Further AMA legal action was taken June 8 on the issue of trade regulation rules on provision of eyeglasses, contact lenses, and eye examinations. The new FTC rule preempts state laws on advertising prices for eyeglasses, contact lenses, and eye examinations and requires that consumers be provided on request with a written prescription for eyeglasses or contact lenses. The AMA questions the authority of the FTC to preempt state laws and the ethical standards of private associations.

SHEPPARD APPROVES MED PRO RATE HIKE

Pennsylvania Insurance Commissioner William J. Sheppard has approved a Medical Protective request for increased malpractice insurance rates. Premium increases for the 6,400 physicians range from 30 percent for surgical specialists to 66 percent for general practitioners who perform minor surgery, assist in major surgery, or do no surgery. Commissioner Sheppard also announced that "effective immediately" Med Pro must give equal consideration for coverage to osteopaths and must adopt a four territory rating system.

STATE LEGISLATION FAVORS SOCIETY STAND

The state legislature in June acted on several bills of interest to PMS. In a 46-0 vote, the Senate approved H-1934, which reduces the physician arbitration fee from $50 to $25. Governor Shapp is expected to sign the bill. SB-752, which gives immunity to physicians issuing instructions in "good faith" to emergency medical technicians, was okayed in the Senate and is awaiting House action. A House vote of 192-3 passed an amended SB-586 permitting the State Board of Medical Education and Licensure to certify physicians' assistants. The amendments would prevent PAs from charging fee for service, independently prescribing or dispensing drugs, and performing certain eye tests. The Senate must now concur on the bill.

FRANKSTON WILL HEAD ARBITRATION OFFICE

Arthur S. Frankston, a Dickinson School of Law professor, has been named by Governor Milton Shapp to serve as administrator of the State Arbitration Panels for Health Care. Frankston, of Carlisle, succeeds Paul F. Abrams, who resigned from the position in May.

FTC SUBPOENAS SOCIETY RECORDS

The Federal Trade Commission on May 10 subpoenaed all State Society records relating to Blue Shield and mandated delivery of the documents to FTC attorneys by July 31. According to the FTC, the purpose of the investigation is, "To determine whether control of the National Association of Blue Shield plans, or participation in such control, by physicians, medical societies, and/or the American Medical Association may constitute unfair methods of competition and/or unfair acts or practices, including price fixing, in violation of Section 5 of the Federal Trade Commission Act."

PMS is complying with the request for information, which extends to peer review, utilization review, fee reviews, articles discussing Blue Shield, the PMS Charter, the Constitution and Bylaws, membership records, correspondence, all publications, and all other documents which relate to the formation of Blue Shield, some going back forty years.

SOCIETY JOINS AMA IN JAIL HEALTH EFFORT

Pennsylvania is one of nine states recently named to participate in the AMA's Program to Improve Medical Care and Health Services in Jails. The program attempts to develop national standards for health care delivery in jails and operates an accreditation system for those that meet standards. The PMS Council on Education and Science has sent letters to sheriffs and medical societies to determine interest in entering the program. Selection of the first five jails to begin the program must be completed by July 21.

SECOND OPINION PROGRAM TO BEGIN IN SEPTEMBER

A voluntary program for second opinions on elective surgery for medicare and medicaid is being initiated by HEW Region III officials. The program, expected to begin in mid-September, must have voluntary participation from doctors to succeed. HEW has recommended that Professional Standards Review Organizations might best develop and hold physician referral lists. The agency is contacting PSROs and state medical societies for assistance in starting the program.

McCOY DECISION EXPECTED SOON

State Society legal counsel expects a decision by fall in the case of Orlo G. McCoy, M.D., of Canton. Dr. McCoy's case was heard June 7 in Commonwealth Court. He is challenging the constitutionality of the mandatory malpractice insurance requirement of Act 111.

MRS. BERGNES ASSUMES AUXILIARY PRESIDENCY

Mrs. Manuel A. Bergnes, of Norristown (Montgomery County), was installed as 1978-79 AMA Auxiliary president at the AMA/AMA Auxiliary convention in St. Louis June 21. Mrs. Bergnes is the seventh AMAA president from Pennsylvania and the second from Montgomery County. Mrs. Spencer J. Servoss, of Williamsport (Lycoming County), took office as AMAA Eastern Regional Legislative chairman at the convention.

NEW CO-OP CATALOG ISSUED FOR SUMMER

The Pennsylvania Medical Cooperative Catalog for summer 1978 was mailed the last week in June to State Society members as a reminder that all PMS members may now buy from the Co-op. Orders may be placed by calling the Co-op toll free at 800-382-1377.

Pennsylvania Medicine

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Cover: Photograph of western Lycoming County by Jack Godlesky.

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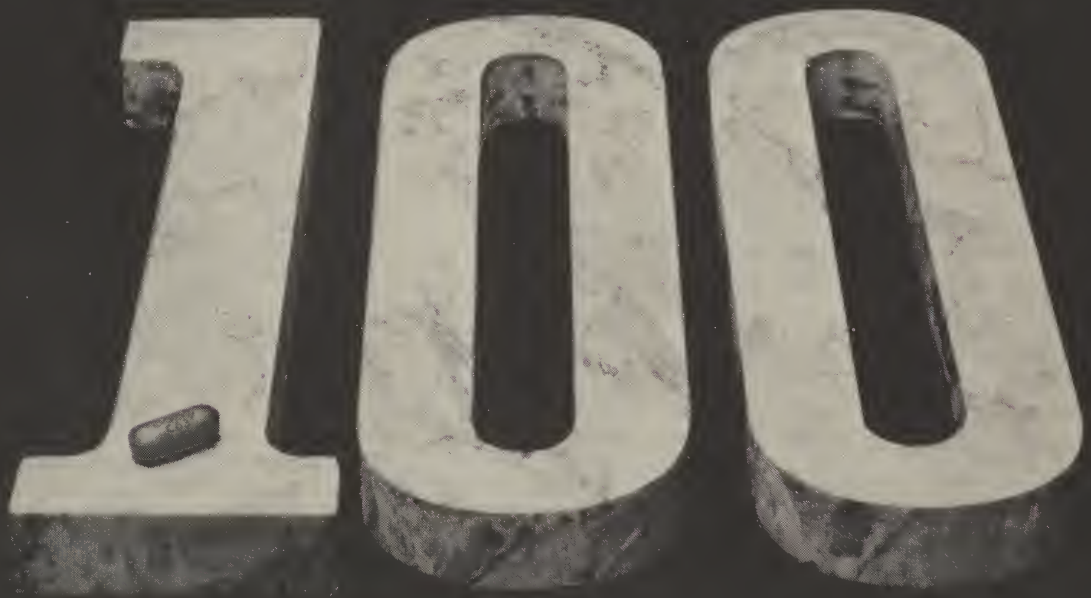
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Child abuse report proves value of Act 124

Reports of suspected child abuse increased 102 percent—to 12,939 in 1977—according to the state Department of Public Welfare's 1977 Child Abuse Annual Report.

State Public Welfare Secretary Aldo Colautti, in a letter submitted to the Governor with the report, stated, "I am saddened to report that during 1977, 4,498 children were found to have been seriously abused under the definitions of Act 124 (the Child Protective Services Act). This is more than the total number of children found to have been abused under the previous statute for the six-year period 1968 through 1974."

The suspicious deaths of 26 children were referred for investigation to county child welfare agencies in 1977, an increase of one case over 1976.

"It is believed that more children died as a result of abuse but were not referred to either ChildLine (the toll-free statewide hotline for reporting suspected child abuse or serious neglect) or the county child protective service units for investigation, as they were processed through the criminal system," the report stated. The ChildLine number is 800-932-0313.

Among other highlights of the annual report are:

- Of the total number of reports received, 5,136 were sufficiently serious to warrant referral to a Child Protective Services worker within 24 hours of the initial report.
- In at least 405 reports, charges were brought against the perpetrator.
- Reports investigated ranged from a low of three in Fulton County to a high of 3,973 in Philadelphia County.

Single copies of the 64-page annual report may be obtained from the Pennsylvania Department of Public Welfare, Bureau of Public Education, PO Box 2675, Harrisburg, PA 17120.

State Board of Medical Education and Licensure statistics as of April 1978 indicate that of the 29,511 physicians licensed to practice in the state, 20,127 hold Pennsylvania addresses, 9,215 hold addresses outside Pennsylvania, and 169 hold addresses outside the United States.

Dr. Collins president elect of ASIM

James A. Collins, Jr., M.D., of Riverside, was named president elect of the American Society of Internal Medicine at its annual meeting in May. ASIM, a national federation of 51 component societies representing more than 15,000 internists, is concerned with the social, political, and economic aspects of medical care.

Dr. Collins, a past president of the Pennsylvania Society of Internal Medicine, has been a member of the ASIM board of trustees since 1972 and has served on many committees.

As a member of the Pennsylvania Medical Society's Council on Education and Science for six years and as its chairman for three years, Dr. Collins was an important force behind implementation of continuing medical education requirements in the state.

Since 1974 Dr. Collins has chaired the Division of Medical Services at Geisinger Medical Center in Danville. From 1958 to 1974 he was director of the center's department of internal medicine and he continues to serve as director of the internal medicine residency program. He was recently elected president of Geisinger's Institute for Medical Education and Research.

He is on the board of directors of Pennsylvania Blue Shield and recently was elected to another three-year term.

A native of Hazleton, Dr. Collins received his medical degree from Jefferson Medical College in 1941. He completed his internship and residency at Geisinger Memorial Hospital and was certified by the American Board of Internal Medicine in 1956.

JCAH mandates study

The PMS Commission on Accreditation at its May meeting reviewed the February 1978 edition of the JCAH *Accreditation Manual for Hospitals* and endorsed several new aspects of the manual's Standard V requiring that "... the medical staff shall participate in a program of continuing education."

In addition to outlining elements that should be included in hospital-sponsored continuing education programs, Standard V mandates that physicians participate in continuing education programs outside their hospitals and that documentation of participation is added to the staff member's credentials file for evaluation at the time of reappointment.

The Standard further calls for participation in local or regional medical society or association programs; credit for professional papers and lectures; participation in self-assessment programs; and training and qualification in basic cardiopulmonary resuscitation techniques.

Emergency physicians install chapter officers

Three new members were elected to the board of directors of the Pennsylvania Chapter, American College of Emergency Physicians at its annual meeting in Philadelphia on May 9.

They are: J. Ward Donovan, M.D., assistant professor of medicine, Emergency Medicine Division, Hershey Medical Center; William O. Robinson, M.D., director of emergency services, Mercy Hospital, Pittsburgh; and Jesse A. Weigel, M.D., medical director of the Emergency Medical Services Institute, Pittsburgh. Roland T. Keddie, M.D., J.D., was re-elected for a second term on the board.

Joseph A. Fortuna, M.D., director of emergency services at the Medical Center of Beaver County, Rochester Unit, Rochester, assumed the duties of president of PaACEP. He succeeds William W. Resinger, M.D., of Titusville.

Charles L. Swisher, II, M.D., Scranton, was named president elect of the chapter. Other officers are: Richard S. Evans, M.D., Pittsburgh, secretary; John R. Paluso, M.D., Washington, treasurer; and Roland T. Keddie, M.D., J.D., member-at-large.

Remaining directors are John W. Becher, D.O., Philadelphia; William F. Blank, M.D., Altoona; Cataldo F. Corrado, M.D., Uniontown; Volney G. Patton, M.D., Bethel Park; and H. William Stewart, M.D., Alexandria.

The PaACEP Chapter office is located at 20 Erford Road, Lemoyne, PA 17043.

Board revokes license

The State Board of Medical Education and Licensure has revoked the license of Jack F. Ostergaard, M.D., of Bethel Park, as a result of Dr. Ostergaard's conviction in September 1976 in California on one count of violating the California Health and Safety Code.

Dr. Ostergaard was convicted of unlawfully obtaining a controlled substance by fraud and deceit. The Medical Practices Act of 1974 provides that conviction of a felony and/or revocation of a license by another state is sufficient grounds for revocation of a physician's license in Pennsylvania.

Dr. Frayer heads PAOO



Dr. Frayer

William C. Frayer, M.D., Philadelphia eye physician, was installed May 18 as president of the Pennsylvania Academy of Ophthalmology and Otolaryngology. New officers also were elected at the Academy's 34th annual convention and scientific meetings.

Dr. Frayer, who was elected to a one-year term, succeeds Silvio H. DeBlasio, M.D., Natrona Heights otolaryngologist. The new president is acting chairman and professor of ophthalmology at the University of Pennsylvania School of Medicine and acting director of ophthalmology at Presbyterian Hospital's Scheie Eye Institute.

Two other Philadelphia physicians also were elected to high offices. Eugene B. Rex, M.D., an otolaryngologist, was named president elect; and Max L. Ronis, M.D., also an otolaryngologist, was elected second vice president. Elected first vice president was James L. Curtis, M.D., a Danville ophthalmologist.

Two Pittsburgh physicians also serving as officers are: George J. Gerneth, M.D., elected third vice president; and Donald B. Kamerer, M.D., reelected secretary. Donald T. Burns, M.D., Wyomissing, was reelected secretary for education.

Guest of honor at the meeting was Raymond E. Jordan, M.D., professor emeritus of otolaryngology at the University of Pittsburgh School of Medicine. William J. Kelly, M.D., of Pittsburgh, immediate past president of the Pennsylvania Medical Society, was an honored guest.

AMA-ERF grants made

Pennsylvania's medical schools received $59,310 in individual grants this spring through the American Medical Association's Education and Research Foundation.

Amounts received by each Pennsylvania school are: Temple University School of Medicine—$14,535; University of Pennsylvania School of Medicine—$11,301; Jefferson Medical College—$10,647; Hahnemann Medical College—$9,014; University of Pittsburgh School of Medicine—$8,910; Pennsylvania State University College of Medicine—$2,510; and Medical College of Pennsylvania—$2,389.

Legal counsel reports

Constitution guarantees right to confront accusers

Fred Speaker, Esq.

The Pennsylvania Superior Court recently published a case[1] which represents the collision of an acknowledged exception to the rule against hearsay evidence with the Constitution. In the case, the Commonwealth sought to establish delinquency based on possession of a controlled substance by the defendant who was at Western Psychiatric Institute and Clinic.

At the hearing, a report by the defendant's psychiatrist, stating that he had observed the defendant instructing another patient in the use of morphine and that the defendant had admitted possession of the morphine was read by another physician. The defendant's psychiatrist did not appear. The trial court admitted the report over the defendant's objection as a hearsay exception under the Uniform Business Records as Evidence Act.[2]

The Superior Court noted that the Act had been used to make admissible facts of hospitalization, symptoms, and treatment. It also reported, however, that expert medical opinion contained in reports is not admissible unless the author is available for cross-examination. Holding that "the doctor's statement identifying the drug was an opinion reporting a conclusion that a lay person is not competent to make,"[3] it stated that the report was not admissible. Furthermore, even if it were held that the report identifying the drug was not opinion evidence, its admission was held to be constitution error:

> To preclude appellant from cross-examining the only testimony supporting his conviction is to deny him the right to confront his accusers as guaranteed by the Sixth Amendment of the United States Constitution and Article 1, § 9 of the Pennsylvania Constitution.[4]

Mr. Speaker is a partner in the firm of Pepper, Hamilton & Scheetz, which serves as the Society's legal counsel.

[1] Commonwealth v. McNaughton, *381 A.2d 929 (Pa. Super. 1977).*

[2] *28 P.S. §91b. which provides: "A record of an act, condition or event shall, in so far as relevant, be competent evidence if the custodian or other qualified witness testifies to its identity and the mode of its preparation, and if it was made in the regular course of business at or near the time of the act, condition, or event and if, in the opinion of the court, the sources of information, method, and time of preparation were such as to justify its admission."*

[3] Commonwealth v. McNaughton, supra *at 931.*

[4] Id. *at 932.*

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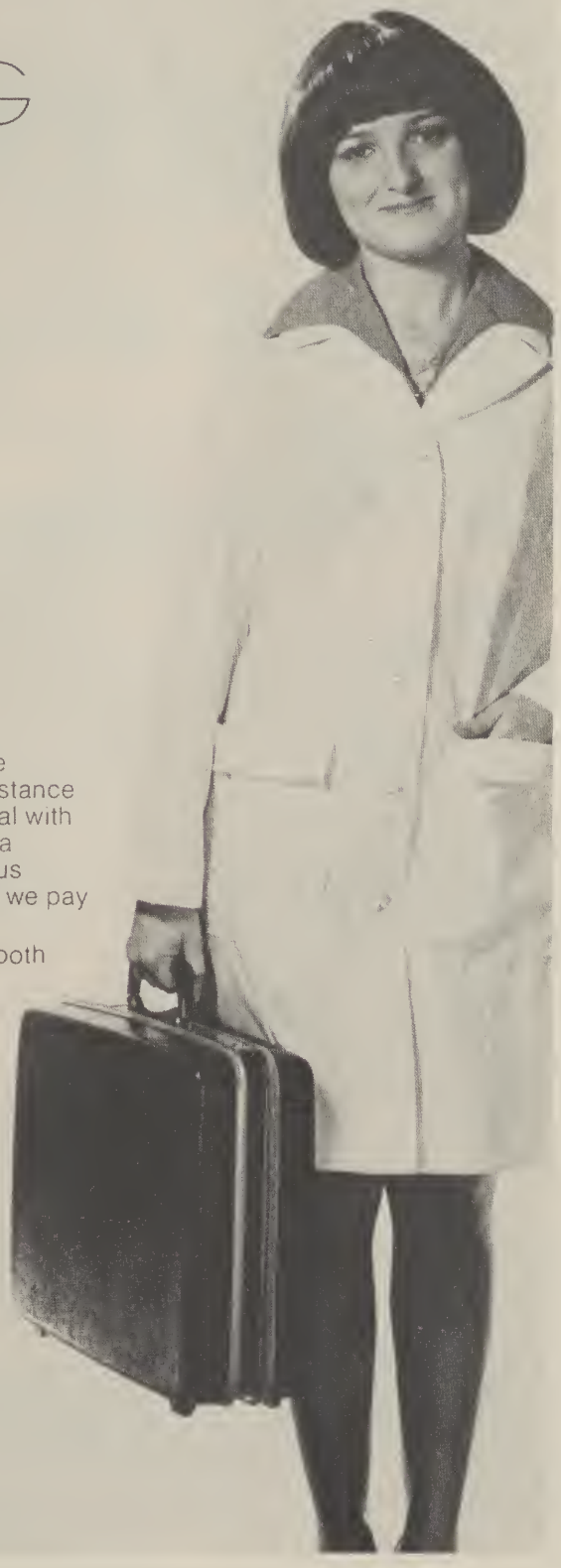
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DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy,* Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.

Final classification of the less-than-effective indications requires further investigation.

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Dosage and Administration: Oral: 10 to 20 mg., three or four times daily. Intramuscular: 5 to 10 mg. (1 or 2 ml.) two or three times daily. Intramuscular administration may be used initially in severe or acute conditions.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Parenteral administration is not recommended in the presence of hypotension or tachycardia.

Intravenous administration should not be given because of increased likelihood of side effects.

Adverse Reactions: On rare occasions oral administration of the drug has been associated in time with the occurrence of hypotension, tachycardia, nausea, vomiting, dizziness, abdominal distress, and severe rash. If rash appears the drug should be discontinued.

Although available evidence suggests a temporal association of these reactions with isoxsuprine, a causal relationship can be neither confirmed nor refuted.

Administration of single dose of 10 mg. intramuscularly may result in hypotension and tachycardia. These symptoms are more pronounced in higher doses. For these reasons single intramuscular doses exceeding 10 mg. are not recommended. Repeated administration of 5 to 10 mg. intramuscularly at suitable intervals may be employed.

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editorials

That the healthy may know of their health

Short-term hospitalizations and crisis-oriented medicine, the changed setting in which modern medicine is practiced, have created an information vacuum which previously did not exist. Expressed concern for the future of the doctor-patient relationship is justified. The patient is drifting away from the traditional relationship that he had with his physician, that of complete trust and interaction in all aspects of health. Doctors are partially responsible for this schism because medical specialization tends to look at diseases and organ systems rather than whole patients as people.

Patient management now includes many trained health professionals. Dieticians, midwives, nurse practitioners, physicians' assistants, and psychologists, to name a few, have direct patient contact. A number of other professionals contribute to the management of patient care but have no patient contact. There is a trend toward large group practices or clinics in which the patient rarely sees the same physician twice, or in which he may see a physician's assistant, for routine care.

A mobile population and large group practices contribute significantly to the breakdown in the doctor-patient relationship.

The importance of patient education in these circumstances cannot be overemphasized. It becomes the responsibility of all health professionals, especially physicians. The concept of informed consent hinges on the patient's knowledge and understanding of his medical problem. The goals, then, of patient education should be (1) the ability of the patient to comprehend his medical condition, its possible complications and prognosis; and (2) the ability of the patient to participate in the treatment program prescribed for his condition.

Hospitals, at the American Hospital Association's urging, have begun to develop patient education programs using trained personnel, classes, visual aids, etc. The AHA's "Statement of the role and responsibilities of hospitals and other health-care institutions in personal and community health education," published in May 1974, advised, "Health education, that is designed to maintain the good health of the community at large and to prevent illness, should be viewed as a service to the community."

Physicians too have begun to realize the need for patient education, if only to prevent further escalation of malpractice. Whatever the motivation, the result seems to be beneficial. The old attitude—that only the doctor should "know"—is passe.

If efforts at patient education are pursued on a continuing basis, improved quality of health care through better patient management should result. At the same time, health care costs should be reduced by better use of hospital facilities, shortened length of stay for admissions, and increased use of outpatient services. As the one to one doctor-patient relationship declines, physicians must accept the responsibility for education to insure that the individual patient can cope with his medical problem. Perhaps, in time, Thomas Carlyle's observation, "The healthy know not of their health, but only the sick . . ." will no longer be valid and we will all know and understand the principles of maintenance of good health.

David A. Smith, M.D.
Medical Editor

in my opinion

Patient package inserts—a good idea gone bad

Twelve years ago in a review of the AMA's second edition of *New Drugs (Ann. Intern. Med. 65: 619-620, 1966)* I asked whether the medical profession was ready for patient package inserts (PPIs). I was concerned that patients weren't warned sufficiently about those hazards only they could avoid, such as sunshine while taking photosensitizing drugs and driving while using drugs with sedative side effects. At that time I wrote: "Since patients are accustomed to certain warnings on proprietary preparations and most enlightened physicians have accepted the inclusion of the name of the drug on the label, are we not ready for package inserts cautioning the patient against hazards only he can avoid? Such cautions could be prepared by the manufacturer, approved by the appropriate government agency, and inserted by the pharmacist on special notation by the physician."

Now another problem has arisen. Congress and the FDA plan to extend the role for the PPI *(A. Hecht, Developing drug information for patients, FDA Consumer 11: 17-19, 1977)* beyond its limited use in over-the-counter preparations. By flirting in the pro-

posed PPIs with two controversial areas—informed consent and standards of care—the FDA will encourage opportunistic malpractice suits, promote self treatment, and increase the costs of medical care.

"Informed consent," that indefinable, paranoid concept uniquely applied to the medical profession *(M. Trout, The patient package insert, J. Leg. Med., 2 (1): 6, 1974)* has no place in a PPI. By its very nature, informed consent is so subjective it invites litigation. In our evolving concepts of consent for medical care we started with implied consent which, though adequate in most situations, was too subjective to be used under all circumstances. Next came expressed consent to be used when the patient's attention had to be focused on some decision, such as surgery. Out of the very special situations presented by clinical investigation came informed consent which, when backed by human experimentation committees and other safeguards, proved adequate. The application of informed consent to PPIs is clearly a case of overkill.

That the FDA can set standards of care through the PPI simply by the choice of words is clear. Even a statement as seemingly benign as recommending an annual physical examination is setting a standard of care. Mentioning that a drug might, under certain circumstances, produce an anemia does not set a standard of care, while suggesting blood counts at certain intervals does. I have serious doubts about including suggested tests and frequencies of visits in package inserts designed for physicians.

If in fact a flood of PPIs is to inundate the American public, who is going to write the PPIs? I hope that it would not be the regulator. (We don't need the referee playing in the game.) Instead, a broad-based, nongovernmental agency, such as the United States Pharmacopeial Convention, would be preferable to both the FDA and the pharmaceutical manufacturers.

By forcing the PPI to do more than it should a good idea has gone bad.

Robert H. Kough, M.D.
Contributing Editor

With government, less is best

I am firmly convinced that the deep frustration most Americans feel toward their government stems from the feeling that they have lost control over the political forces that control their lives.

Too many decisions which should be made by state or local government are instead being made by the federal grovernment. These federal personages have come to believe there is a federal solution—that "big government can do anything bigger or better than anybody else." This is a singular Potomac disease which has caused untold grief in the last 40 years.

Big government has displayed its might in the entire spectrum of human affairs, from what is best for you and me to eat to the enactment of moral principles that have become the law of the land.

And this same government has made blunder after blunder. Witness their foreign policy decisions, their management of government bureaus such as the U.S. Postal Service and Social Security Administration, their ineffectiveness in halting inflation, and on and on.

Can we believe in a government that cannot balance a budget, that prints paper money in ever-increasing amounts, that enacts laws and regulations that stagnate the individual and businesses that contribute to the very heart of government? The answer is a resounding no!

Recent polls show only 19 percent of the people are convinced the communications media gives the news in an unslanted manner and less than 30 percent of all people feel they get their money's worth from the taxes they pay. The disenchantment runs deep.

People in any type of business, large or small, can testify to the number of government forms that must be filed or the number of regulations that must be obeyed.

As an example, an American steelmaker must observe 92 regulations in the making of one ton of finished steel. Of course, in its great wisdom, the government has left the cost and burden of obeying these regulations to the steelmaker. Is there any wonder why costs are so high and lack of productivity is so evident in the American system?

Granted, there is need for regulation and conformity but the degree to which the federal government imposes its will is less than desirable.

Maybe we should change the course of thinking of the people who go to Washington. Possibly by limiting the tenure of their elective office. By limiting his term, it will serve to remind a legislator he is not, by virtue of election, a member of some ruling class ensconced in Washington, but a citizen on leave to his government. With this format, perhaps people in lower levels of local and state government would be encouraged to "do for themselves" in a more productive way.

The solution requires a generalized positive attitude—to begin to believe firmly that the best government is that with the least amount of bureaucracy. It seems reasonable to begin this process soon.

Gerald L. Andriole, M.D.
Twelfth District Trustee

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For county medical societies

Public service, education equal good public relations

Robert L. Lamb
Director of Communications

The public relations of organized medicine suffers from neglect—either too little or nothing is done about it. Efforts to improve physician public relations all too often consist of throwing money at the problem.

Between these extremes of doing nothing or spending lavishly are a surprising number of practical measures that can be taken. Many of these ideas require minimal investment of time and money. Some have been tried with success by county medical societies and auxiliaries across the state. This article proposes to transmit this information in hopes that physician public relations will receive the necessary attention.

What the polls say

There is no shortage of polls regarding the public's attitude toward the medical profession. Some indicate that physicians still rank at the top of the professionals' list in public esteem. Others say doctors are well trained and efficient. Most polls show high patient satisfaction with the respondent's private physician but disenchantment with the medical profession collectively.

A survey conducted by the Pennsylvania Medical Society several years ago confirmed a Salt Lake City poll which saw doctors as overworked, inaccessible, overpaid, and disinterested. Pennsylvanians found physicians less interested in their patients and more concerned about fees.

Generally, the polls indicate that physician compassion, not physician competency, is on trial. The public senses that physicians are growing callous and insensitive to their patients' feelings.

Making county societies count

When press releases are substituted for public action, public relations programs frequently fail. Nowhere is the cliche "actions speak louder than words" more appropriate than in public relations. Public relations, according to one textbook definition, is *"doing* good and getting credit for it."

Physicians should not expect to secure public recognition as a special group by performing their jobs well and saving lives.

Physicians as a group must go beyond these duties.

Good physician PR depends on the county medical society which provides a forum where groups of doctors can perform humanitarian services for the community and receive public recognition.

Choosing the service to be performed is the crux of the dilemma. Members of a county medical society must have the time and funds to perform a project in which the community has expressed an interest and for which the society gets proper recognition. Periodic perusal of the local newspaper through PR glasses should soon reveal community problems suitable for county medical society action.

Some ideas for your county society are:

- Prison health—The AMA has taken the lead by launching an investigation into health conditions in our jails. Local follow-up is needed.
- TV violence—Motherhood and the AMA unite in the battle against TV violence, and county medical societies can join the ranks by providing speakers to local parent/teacher organizations and other interested groups.
- Immunization—Public regard for state physicians was never higher than during the polio vaccination programs. County medical societies provided volunteer physicians to assist in the public's immunization. Immunization (swine flu notwithstanding) remains an activity with high public relations potential.
- Emergency medicine—The public's understanding and expectation of emergency care has changed dramatically from the World War II image of Red Cross first aid courses. Most per-



Radio and television are media with which physicians can work. David A. Smith, M.D., medical editor of PENNSYLVANIA MEDICINE, is shown above taping his weekly five minute radio show. Below, Thomas F. Fletcher, Jr., M.D., president of the Dauphin County Medical Society, and Bernard Margolis, M.D., immediate past president, prepare for the live broadcast of "Medicall," a project of the Dauphin CMS and WITF-TV.



sons today are aware of the newer life saving techniques, such as CPR. Volunteer ambulance crews, selected school classes, and members of the general public seek emergency training. The county medical society can provide qualified emergency medical leadership, which unfortunately has fallen to non-physicians in some instances.

• Physical fitness—America is on a fitness kick. Local news media, government, and civic organizations are looking for bona fide leadership in physical fitness. County medical societies can provide that leadership.



The Benjamin Rush Awards Program historically has given county societies good PR. Shown above, Mrs. Doris Stetler receives the award of the Delaware County Medical Society from Richard J. Morris, M.D. Below is a new PR tool available from the State Society for use by county societies at health fairs, shopping malls, etc.



Public school market

The Pennsylvania Department of Education requires health instruction in our schools. In the elementary grades, the textbook giants of the nation provide a comprehensive series of books. But at the junior and senior high school levels, teachers must create their own instructional materials. Many requests which have come to PMS indicate that secondary teachers would welcome county medical society help.

School officials also tell us that the need for good teaching materials on drugs and VD is extremely high. This demand comes at a time when, because of cost considerations, the Pennsylvania Department of Health has abolished its film library. County medical societies are in an ideal position to provide the financial support to purchase audiovisual materials relating to VD and drugs.

Many school libraries are inadequately stocked with health resource materials. Without the necessary funds, they cannot purchase subscriptions to health periodicals. Again, county medical societies may provide the literature or the funds to equip the libraries with these materials.

School nurse seminars

As responsibility for school health shifts to school nurses, the need for greater liaison and communication with school nurses grows. Mercer County Medical Society held a regional seminar for school nurses last year. School nurses from Mercer and surrounding counties and Mercer

Continued on page 24

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Financial facts of life a must for physicians

Leif C. Beck, LL.B., C.P.B.C.
Vasilios J. Kalogredis, J.D.

The medical profession provides a great service but it is also a business, a fact which physicians in private practice should not ignore.

We are amazed by the number of physicians in private practice who have no interest in or knowledge of the most basic financial aspects of their practices. In many cases this lack of interest is due to the fact that medicine is a high-income profession. As many physicians will admit, it is routine for doctors to earn a comfortable living "in spite of themselves" as far as financial and business management is concerned.

As the cost of living continues to rise and governmental and insurance contraints proliferate, however, there will be increasing pressure on physicians to become more informed about their practice finances and efficiencies.

This two-part series focuses on the financial data a physician should expect to receive on a regular basis.

Monday morning report

A physician should receive weekly information on the practice's more important figures. A sample of a "Monday morning report" is included as Figure 1. On the report, space is provided for eight weekly summaries in order that comparisons may be made. Many physicians have found it useful to punch holes in these sheets and place them in a looseleaf notebook for easy reference and comparison.

The summaries may aid in spotting trends and warding off difficulties before they become serious. Too often the problems inherent in a practice have gone unnoticed for a long time because weekly or monthly financial reports were not prepared or made available to the physician and his advisors. When the problem does surface, it is of crisis proportions and more difficult to resolve.

The sample report lists cash in the bank and on hand as of the beginning of business on Monday morning and an estimation of receipts for the coming week. Bills payable also are summarized so the doctor will know where the practice stands. Many find it appropriate to attach separately a list of bills outstanding. From this the doctor may establish a payment priority list in light of estimated income for that week.

An accounts receivable figure is included on the sample report. Many practices do not legitimately know what this figure is, and physicians often are shocked when they find out how large it is. When the figure is seen by the physician every week, unusually large increases or decreases in receivables are clearly noticeable. Any necessary corrective action can be taken promptly, in a timely and informed way, before the situation gets further out of hand.

Insurance forms pending also is an important category. Included within this is the number of forms to be completed, the date of the oldest, and the approximate value of such pending insurance forms. This is another area in which medical practices are often poorly informed.

The "Monday morning report" may be tailored to the practice's needs and should reflect information that is most relevant and helpful to it. Such information may include numbers of people admitted to the hospital, numbers of different types of visits, and the like.

Monthly accounting statement

An unfortunately large number of medical practices receive financial statements only on a quarterly, semi-annual, or annual basis. To make matters worse, the reports often end up in the physician's hands many months after the fact, thus becoming historical documents rather than timely and effective management tools. This situation must be remedied.

Most accountants prepare formal financial statements for small medical practices. They generally provide a balance sheet setting forth the practice's assets and liabilities, and an income and expense statement

The authors are the principal consultants of Management Consulting for Professionals, Inc., Bala Cynwyd.

FIGURE 1
Monday Morning Report

	/ /	/ /	/ /	/ /
Cash in bank and on hand	$			
Estimated receipts (week)				
Total	$			
Accounts payable:				
Payroll for week	$			
Installments or loans				
Other current				
Total	$			
Total accounts receivable				
Insurance forms pending				

showing the financial progress during the period from a profit and loss point of view.

Although helpful, these formal statements often do not contain the kind of information physicians and their advisors need for practice business decisions. In addition, their infrequency (and in many cases, delay) and form (often lengthy and indigestible) tend to make them less than helpful. Such formal accountant's statements should be augmented by less official, more relevant, and more timely internal reports.

In-office monthly financial statements should be prepared for large practices and solo practitioners alike. This is best accomplished by charging the practice's bookkeeper with the responsibility of providing an informal monthly statement. The bookkeeper should submit the statement within the first few days of any month (usually by the 10th) so that it can serve as a timely piece of information for quick review by the physicians, the office manager (if involved at this level of management), and the practice's advisors.

Group practices should hold regularly scheduled monthly meetings to discuss practice management and financial matters. The financial statement serves as an important agenda item at each meeting and helps physicians and advisors avoid making decisions in a vacuum. Never should physicians be expected to discuss practice matters without being aware of all relevant information.

We are amazed by the number of medical offices whose most recent financial information is a year or more old. In March, for instance, we visited a solo unincorporated physician whose only financial information available for review was his practice's 1976 tax return. Obviously, it is difficult to deal with practice matters without more current information. It was particularly unfortunate in his case because the problems that had developed might have been averted, or at least diminished, if he had had more current information. Such data would have "sounded the alarm" for corrective action before a crisis occurred.

Virtually all the information necessary to prepare an in-house monthly financial statement is already produced by most practice bookkeepers. An accountant or consultant usually trains the bookkeeper to summarize all receipts and to categorize all expenditures. A pegboard checkwriting system is particularly helpful and convenient in making the expense breakdowns in-house. The cost of preparing the in-house statement doesn't require the accountant's training and is well within the capabilities of the typical bookkeeper.

Doctors must be aware of the financial status of their practices at all times, the authors maintain. In this article they demonstrate a method for achieving this goal.

The office should work closely with its accountant or consultant for assistance in preparing the monthly information form. In addition, a copy of the form should be sent each month to the accountant, consultant, and/or attorney as a useful method of keeping them informed and involved in the practice.

The statement form should be designed for quick, concise, and complete presentation of information on a single sheet of paper. Most busy doctors have little time for or interest in reviewing complex and lengthy financial reports.

Offices that have a computer service which provides a breakdown of charge, receipt, and expense items by categories should still produce a single summary sheet of important items from that computer printout. A simple reference sheet is more practical and useful to a busy physician than are reams of computer sheets.

A suggested style for such an in-house monthly financial statement will be included as part of next month's article. □

Librax®

Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

Please consult complete prescribing information, a summary of which follows:

Indications: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma; prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Br.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**

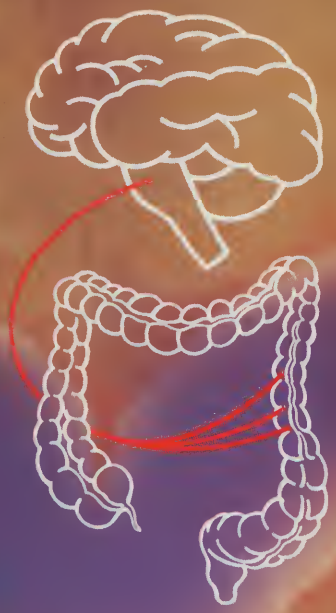
As with all anticholinergics, inhibition of lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

ROCHE

Roche Products Inc.
Manati, Puerto Rico 00701



In treating irritable bowel syndrome*

Enhance your therapeutic expectations with

Librax®

Each capsule contains
5 mg chlordiazepoxide HCl
and 2.5 mg clidinium Br.

antianxiety/antispasmodic/antimotility

Librax is unique among G.I. medications in providing the specific antianxiety action of LIBRIUM®(chlordiazepoxide HCl) as well as the potent antispasmodic and antimotility actions of QUARZAN®(clidinium Br) for adjunctive therapy of irritable bowel syndrome.

ROCHE

Librax has been evaluated as possibly effective for this indication.
Please see brief summary of prescribing information on preceding page.

Modane®
(danthron)
LAXATIVE TABLETS
one tablet usually brings
gentle, overnight relief
WARREN-TEED
LABORATORIES, INC.
DIVISION OF AORIA LABORATORIES INC.
COLUMBUS, OHIO 43215

Public service equals good PR

Continued from page 19

County physicians joined at the all day meeting. Physicians spoke about visual evaluation of school children, hearing evaluation, nutrition, immunizations, musculoskeletal problems, infections, and emotional problems. According to Mercer County Medical Society president Theodore Yarboro, M.D., the program paid for itself and formed the basis for future nurse seminars.

Media coverage

Newspapers—In the absence of a planned PR approach to the public media (newspapers, radio, TV), most county medical societies become public relations firefighters. The Society remains silent until a problem comes up. An alternative to this passive relationship is provided by the State Society. Weekly health columns produced by the Society offer the means to establish an ongoing, active relationship with local newspapers.

Radio—The State Society also produces a weekly five minute radio program which reviews health issues and is heard on stations throughout the state.

Television—Nowhere is the power of television better illustrated than in the world of politics where the prize goes to the contender who projects the best image. Accordingly, in 1976, the Pennsylvania Medical Society sponsored its first television training seminar for leaders of organized medicine. Physicians who completed the two-day course report that it has been invaluable to them in improving their presentations on the air. The State Society plans more TV training seminars.

Awards program—Under the Council on Professional Relations and Services, the Society continues to sponsor a comprehensive awards program. Properly administered, awards can secure favorable press coverage.

- Benjamin Rush Awards—Every county medical society is encouraged to hold a local Benjamin Rush Awards program. The awards are presented to lay individuals and groups for outstanding volunteer service. Participating on the local level makes the county society eligible for the statewide contest.
- Fifty Year Award—Some of the best newspaper coverage has occurred with the presentation of the Fifty Year Award to a beloved community physician. Properly planned award ceremonies have the potential to become good stories with photo coverage.
- Environmental Improvement Award—Conservation and other environmental concerns rate high with the public. This award demonstrates organized medicine's concerns for the community as well as the individual. Another advantage of the award is that it offers the county societies the opportunity to recognize industries and volunteer groups. The state environmental award program also offers additional coverage to local winners.
- Centenarian Award—County medical societies present this award to Pennsylvania citizens who are celebrating their 100th birthdays. Awards are supplied to county societies free of charge on request.

Exhibits—Even in this electronic age, fairs continue to be popular. County fairs, health fairs, professional and trade association meetings, shopping centers, hospital lobbies, or any location with high pedestrian traffic is a potential site for an exhibit. The State Society has developed an exhibit which includes recorded health information that is available free of charge from PMS. The exhibit is professional in appearance and has been well received. It fits into four carrying cases for ease of shipment.

Physician directories—A frequent criticism from the public is that physicians are hard to find. New families moving into an area experience this difficulty most severely. Organized medicine has executed a relatively new concept, the physician directory. Outstanding examples in our state come from the Allegheny County Medical Society and the Lancaster County Medical Society.

This is just the tip of the iceberg. Many county medical societies and auxiliaries have successful public relations programs. Tell us about yours, today, so that we can spread the news. □

A Difference in Theophylline Therapy

micro-pulverized

BRONKODYL® Capsules

brand of theophylline, USP anhydrous



- Blood levels as fast as an elixir
- With minimal gastric irritation*

*Please see complete prescribing information, a summary of which follows.

DESCRIPTION:
Each green and white hard gelatin capsule contains theophylline USP anhydrous, 200 mg., in a micro-pulverized form. Each brown and white hard gelatin capsule contains 100 mg. The elixir contains 80 mg. theophylline per 15 ml. in a 20% alcohol elixir (approximately 20 calories, 0.9 gm carbohydrate per tablespoonful).

ACTION: Theophylline is a methylxanthine which relaxes the smooth musculature of the bronchioles through its inhibition of the conversion of cyclic adenosine monophosphate to adenosine monophosphate by phosphodiesterase. It also has diuretic, cardiotonic, and CNS stimulant effects.

INDICATIONS: Bronkodyl is indicated for symptomatic relaxation of bronchiolar spasm in the chronic obstructive bronchopulmonary diseases; e.g., bronchial asthma, chronic bronchitis and pulmonary emphysema.

CONTRAINDICATIONS: Bronkodyl is contraindicated in persons known to have had serious idiosyncratic responses to theophylline, its salts, or the other methylxanthines, theobromine, or caffeine and may be contraindicated in peptic ulcer.

WARNINGS: All methylxanthines should be used with caution in children and in others who are currently taking bronchodilator products, especially in rectal dosage form, which may contain theophylline or related drugs.

USAGE IN PREGNANCY: Although theophylline has been used for many years, with no evidence of adverse fetal effect or teratogenicity, its safety in pregnancy has not been established. Therefore use of Bronkodyl during lactation or in women of childbearing potential requires that possible benefits of the drug be weighed against possible hazards to fetus or child.

PRECAUTIONS: Bronkodyl should be used with caution in patients with cardiac or circulatory disease.

ADVERSE REACTIONS: Gastrointestinal: Epigastric distress, nausea, vomiting. Cardiovascular: palpitations. CNS: Insomnia, restlessness, irritability, convulsion.

DOSAGE AND ADMINISTRATION: Adults: Usual dosage of Bronkodyl is 200 mg. every 6 hours (four doses in each 24 hours). This dosage may be adjusted to reflect individual clinical response as an indication of slow or rapid metabolism of the drug. If adverse reactions are encountered, each dose may be reduced, or the interval between doses may be lengthened, or both. If clinical response is not satisfactory, indicating possible rapid inactivation of the drug, dosage may be gradually increased to achieve the desired response. In some instances of either too slow or too rapid metabolism, plasma levels of theophylline should be determined and dosage adjusted accordingly to achieve levels above 10 mcg/ml, but not to exceed 20 mcg/ml.

Dosage in Children: Usual dosage should be based on administration of 10 mg per kg per 24 hours, divided in 4 doses per day, given every 6 hours. As this may not be possible with use of the capsules, Bronkodyl elixir may be used. Theophylline saliva levels (approximately 60% of simultaneous blood levels), may facilitate dosage adjustments, especially in children, to obtain appropriate response.

HOW SUPPLIED:
Bronkodyl 100 mg., brown and white capsules in 100's, Code #1831.
Bronkodyl 200 mg., green and white capsules in 100's, Code #1833.
Bronkodyl Elixir, 80 mg. per 15 ml, in pints, Code #1835.

BREON

BREON LABORATORIES INC.
90 Park Avenue, New York, N.Y. 10016

Time is the test of all things.

1954
1978



BRIEF SUMMARY

Indications: Oral potassium therapy for the prevention and treatment of hypokalemia which may occur secondary to diuretic or corticosteroid administration. May be used in the treatment of cardiac arrhythmias due to digitalis intoxication.

Contraindications: Severe renal impairment with oliguria or azotemia, untreated Addison's disease, adynamia episodica hereditaria, acute dehydration, heat cramps and hyperkalemia from any cause.

Precautions: Potassium intoxication by oral administration rarely occurs in patients with normal kidney function, however, potassium supplements must be administered with caution, since the amount of the deficiency or daily dosage is not accurately known. Frequent checks of the clinical status of the patient, and periodic ECG and/or serum potassium levels should be made. High serum concentrations of potassium ion may cause death through cardiac depression, arrhythmias or arrest. This drug should be used with caution in the presence of cardiac disease.

In hypokalemic states, especially in patients on a low-salt diet, hypochloremic alkalosis is a possibility that may require chloride as well as potassium supplementation.

Adverse Reactions: Nausea, vomiting, diarrhea, and abdominal discomfort have been reported. The most severe adverse effect is hyperkalemia.

Overdosage: Potassium intoxication may result from overdosage of potassium or from therapeutic dosage in conditions stated under "Contraindications". Hyperkalemia, when detected, must be treated immediately because lethal levels can be reached in a few hours.

Kaon® Elixir
(potassium gluconate)
20 mEq per 15 ml

WARREN-TEED
LABORATORIES, INC.
DIVISION OF **ADRIA LABORATORIES INC.**
COLUMBUS, OHIO 43215

Commission calls for voluntary improvement

Physician manpower distribution subject of report

Geographic and specialty distribution of physicians is a key problem facing organized medicine in Pennsylvania, according to a recent report by the State Society's Commission on Education and Manpower.

The Commission concludes: "Distribution—rather than physician shortage or overage—will remain the object of state and federal legislation. If organized medicine is concerned with government manipulation and intervention into medical education and training, it should undertake concerted efforts to resolve problems of physician distribution through voluntary means."

The report, an update of information from 1973-74 data last published in the March 1975 issue of PENNSYLVANIA MEDICINE, analyzes physician supply and distribution in the Commonwealth using 1976 data supplied by the state Department of Health.

The data indicate that:

- Pennsylvania still ranks high in total number of physicians in direct patient care. In 1976 Pennsylvania ranked sixteenth in the United States with one physician for every 778 people, compared with eleventh in 1974 with one for every 627.
- Geographic centralizing of physicians in urban rather than rural areas continues.
- A shortage of primary care physicians continues.

In light of the Commission's findings, the report recommends that:

- The Pennsylvania Medical Society should encourage programs to increase availability of primary care physicians. Among these programs are the vast number of primary care residencies throughout the state.
- The State Society should encourage decentralized medical education at graduate and undergraduate levels. Current studies suggest that selection of rural students and high exposure to a rural setting may be effective in influencing geographic distribution.
- With improved data collecting techniques comes the ability to predict physician shortage due to retirement and influx of foreign medical graduates. Early planning is recommended to meet possible physician shortages.

A summary of the Commission report follows.

Physician distribution

In November 1976 questionnaires accompanying license renewals were mailed to all medical doctors licensed in Pennsylvania. Ninety-two percent, or 23,923 of the 26,035 physicians renewing their licenses, responded.

The data indicate that Pennsylvania's physician to population ratio has improved since 1975 in urban areas and Standard Metropolitan Statistical Areas. Few counties have seen a decline in the ratio, and in several the ratio has improved dramatically due to the presence within their borders of medical centers, medical schools, and teaching institutions. An exceptional example is Montour County, in which the current ratio of one physician for every 98 people reflects the presence of a tertiary care medical center which draws patients from other counties.

Shifting physician distribution in Pennsylvania is illustrated in Figure 1, which shows total distribution of MDs and DOs, and Table 1, which gives individual county statistics. Twenty-one counties have lost doctors, forty have gained, and six remain unchanged.

Availability of primary care

A clear picture of access to medical care in Pennsylvania emerges with measurement of the number of primary care physicians available and their distribution throughout the state.

Comparison of the new data with ratios from the 1975 study indicates an overall increase in the availability of primary care *based on these statistics*. Other factors influencing the need for primary care, such as age of population, disease prevalence and severity, general economics of the population, and ability to secure medical services, are not weighted in this study.

The current ratios include physicians who listed as their primary area of practice the following specialties: family/general practice, general preventive medicine, geriatrics, internal medicine, obstetrics/gynecology, and pediatrics.

Various study groups have estimated the number of primary care physicians necessary to meet the medical needs of a given population. These estimates range from one primary care physician for every 752 people to one for every 1,585.

A study of the county ratios of family/general practice physicians to population shows that almost all counties in Pennsylvania still fall short of an ideal ratio. Most studies estimating the need for family physicians place an ideal number at one for every 2000-2500 people. Pennsylvania's overall ratio is one for every 4,069 people.

The Commission's 1975 study indicated a need to increase family/general practitioners by 25 percent. Since then the number has increased

by 102, from 2,813 to 2,915 (3.2 percent)—far from the 703 recommended.

Influences on distribution

A major influence on specialty distribution in the past three years is the increase in family practice residencies. In 1969 there was one family practice residency; this number increased to 18 in 1974 and stood at 29 in 1976. As of December 1976, 311 residents, 98 of whom were in their third year, participated in the 29 programs.

Other influences on the supply of physicians in direct patient care are the age of practicing physicians and the number of foreign medical graduates practicing in the state.

Analysis of the statewide age distribution of physicians shows that 30 percent are 55 and over. In 12 counties—Bedford, Cameron, Clarion, Fayette, Forest, Franklin, Indiana, McKean, Schuylkill, Sullivan, Wayne, and Wyoming—25 percent or more of active physicians are over 65.

Foreign medical graduates (FMGs) comprise 19.3 percent of active medical doctors in the state. Of the total of 2,040 new licenses granted in 1976 by the State Board, 707 were granted to foreign medical graduates. Current legislation aimed at tightening requirements for entering the United States may reduce this source of physician manpower.

The full Commission report is available from the PMS Council on Education and Science, 20 Erford Rd., Lemoyne, PA 17043.

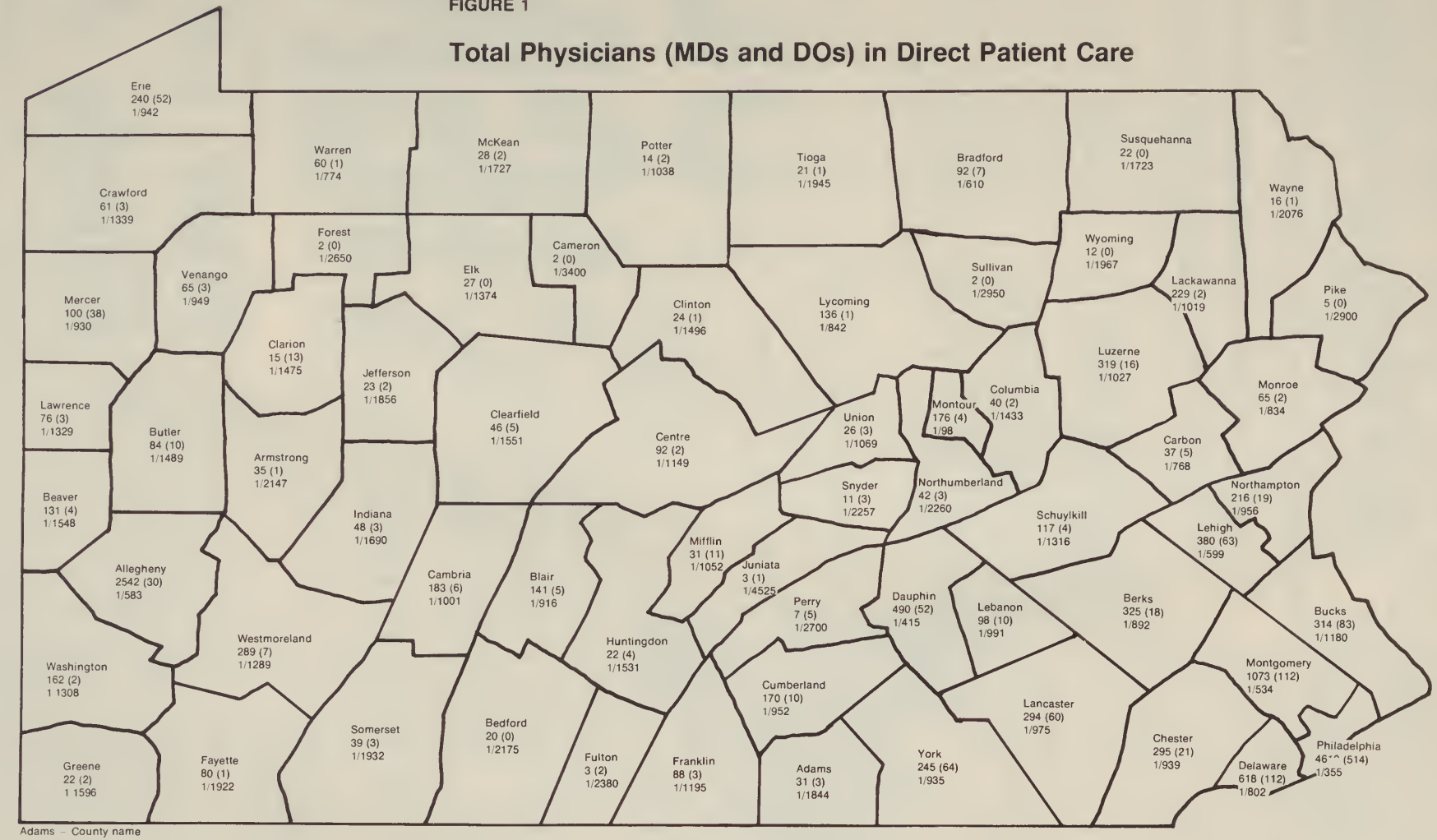
TABLE 1
Statistical Profile of Pennsylvania Counties (1976)
(Total population 11,862,000)

County	*No. MDs 12/76*	*+/−**	*Physician/ population ratio*	*County*	*No. MDs 12/76*	*+/−**	*Physician/ population ratio*
Adams	31	−2	1/2,033	Lackawanna	229	−4	1/1,028
Allegheny	2,542	+632	1/590	Lancaster	294	+15	1/1,174
Armstrong	35	+3	1/2,209	Lawrence	76	−1	1/1,382
Beaver	131	−8	1/1,595	Lebanon	98	+11	1/1,092
Bedford	20	−1	1/2,175	Lehigh	380	+101	1/698
Berks	325	+2	1/941	Luzerne	319	+30	1/1,078
Blair	141	+12	1/949	Lycoming	136	+32	1/848
Bradford	92	+20	1/656	McKean	28	−2	1/1,850
Bucks	314	+20	1/1,492	Mercer	100	+4	1/1,283
Butler	84	+8	1/1,667	Mifflin	31	0	1/1,426
Cambria	83	+17	1/1,033	Monroe	65	+6	1/860
Cameron	2	0	1/3,400	Montgomery	1,073	−133	1/590
Carbon	37	+2	1/1,411	Montour	176	+82	1/98
Centre	92	+14	1/1,174	Northampton	216	−24	1/1,040
Chester	295	+34	1/1,006	Northumberland	42	−8	1/2,421
Clarion	15	+4	1/2,753	Perry	7	0	1/4,629
Clearfield	46	+4	1/1,720	Philadelphia	4,610	+1,999	1/394
Clinton	24	−7	1/1,558	Pike	5	−2	1/2,900
Columbia	40	−1	1/1,505	Potter	14	+2	1/1,186
Crawford	61	−5	1/1,404	Schuylkill	117	0	1/1,361
Cumberland	170	−20	1/1,008	Snyder	11	−2	1/2,873
Dauphin	490	+187	1/459	Somerset	39	+5	1/2,031
Delaware	618	−57	1/949	Sullivan	2	0	1/2,950
Elk	27	+2	1/1,374	Susquehanna	22	+3	1/1,723
Erie	240	+32	1/1,146	Tioga	21	+1	1/2,038
Fayette	80	−3	1/1,946	Union	26	+6	1/1,192
Forest	2	−1	1/2,650	Venango	65	+9	1/992
Franklin	88	+7	1/1,235	Warren	60	+19	1/787
Fulton	3	+1	1/3,967	Washington	162	+24	1/1,324
Greene	22	+3	1/1,741	Wayne	16	+4	1/2,206
Huntingdon	22	−3	1/1,809	Westmoreland	289	+25	1/1,320
Indiana	48	+3	1/1,796	Wyoming	12	0	1/1,967
Jefferson	23	−4	1/2,017	York	245	+27	1/1,179
Juniata	3	−2	1/6,033	**Total**	15,232	**Total** +3,082	**Average** 1/778

*Increase or decrease in M.D.s from 1974 statistics.

FIGURE 1

Total Physicians (MDs and DOs) in Direct Patient Care



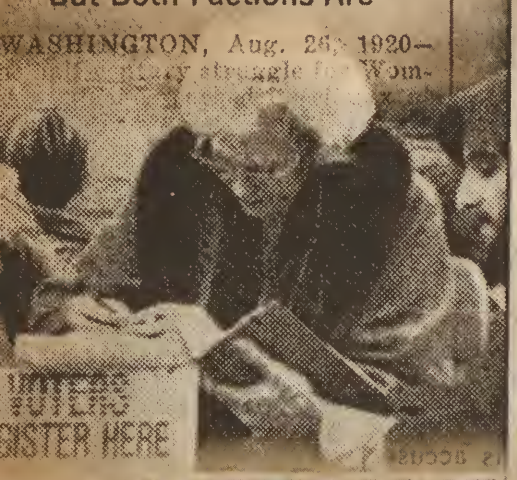
Adams – County name
31 (3) Number of MDs (DOs) in county
1 1844 – Ratio of physicians (MD and DO) to population

COLBY PROCLAIMS WOMAN SUFFRAGE

...igns Certificate of Ratification at His Home Without Women Witnesses.

MILITANTS VEXED AT PRIVACY.

Wanted Movies of Ceremony, But Both Factions Are



Social Security Bill Is Signed; Gives Pensions to Aged, Jobles

Roosevelt Approves Message Intended to Benefit 30,000,0 Persons When States Adopt Cooperating Laws–He Call the Measure 'Cornerstone' of His Economic Program.

WASHINGTON, Aug. 14, 19 The Social Security Bill, provi a broad program of unemployn insurance and old age pensi and counted upon to benefit s 20,000,000 persons, became law day when it was signed by P dent Roosevelt in the presenc those chiefly responsible for ting it through Co s.

Mr. Roosevelt cal mea "the cor erstone struc whi is eing me s c ple ri to

SENATE APPROVES 18-YEAR OLD VOTE IN ALL ELECTIONS

Amendment to Constitution is Sent to House, Where Passage is Expected

WASHINGTON, March 10, 1971—The Senate approved today, 94 to 0, and sen to

TRUMAN CLOSES ...TED NATIONS CONFEREN ...TH PLEA TO TRANSLATE ...CHARTER INTO DEEDS

NEW WORLD HOPE

President Hails 'Great Instrument of Peace,' Insists It Be Used

HISTORIC LANDMARK

Meeting Gives Standing Ovation as Executive Pictures Peace Gain

"If we fail to use it," he declared to the solemn final meeting of the delegates, 'we shall betray all of those who have died in order that we might meet here in freedom and safety to create it.'

"If we seek to use it selfishly—for the advantage of any one nation or any small group of nations—we shall be equally guilty of that betrayal."

Fervent Interpolation

The President, speaking in the auditorium of the War Memorial Opera House, built in memory of sons of the Golden Gate city who gave their lives in the first World War, in which he himself served, seemed to give unconscious expression to the solemn feeling of the occasion when, at the outset of his speech, he interpolated the words, half a hope, half a prayer:

"Oh, what a great day this can be in history!"

Just before the plenary session the President accompanied the

...UL ...IGNE ...the Draft ...Ends Nov

WASHINGTON, Jan. 27, 1973—"With the signing of the peace agreement in Paris today, and after receiving a report from the Secretary of the Army that



PATIENT PACKAGE INSERTS: A CONCEPT WHOSE TIME HAS COME?

The consumer's right to know is an irreversible and desirable trend of the Seventies. It extends, and properly, to a patient's right to know more about his or her prescription medications. One way, gaining favor, is through patient package inserts. Wisely-prepared and properly distributed when medically indicated, they could markedly improve patient knowledge and drug therapy—laudable goals by anyone's standards.

The PMA endorses these goals and will work with government, the health professions and consumers to achieve them.

The Advantages

The concept holds promise of benefits: better patient understanding of the product prescribed, better adherence to the treatment plan, and more awareness of possible side reactions.

Every doctor has had patients who fail to finish antibiotic regimens because they feel better. Some patients assume that if one tranquilizer or analgesic is good, two may be twice as good. Still others fail to report dizziness while on antihypertensive therapy —and so on.

Problems like these might arise less often if the patient received written information in addition to verbal instructions. Some studies suggest that patients are more receptive to such materials, and they more often understand the verbal instructions and follow them, when inserts are used.

The Disadvantages

There are also some potential problems. Obviously, the inserts must be clearly phrased, without extraneous or complex detail. How much information is enough? How can it be kept current? Should all patients receive the same information? Should inserts be included with all drugs? Should only potential problems be listed or are patients better off with a "fair balance" presentation that describes usefulness as well as drawbacks?

These and similar questions require answers, since model inserts have yet to be properly developed and tested. Despite the need for these studies, the FDA is proceeding prematurely with inserts on selected products. We think the Congress is the only place where the matter can be given the proper legal status and direction, particularly since it represents a conceptual change in the legal, medical and social framework of the nation's prescription drug information system.

The Solution

The PMA believes that carefully-devised pilot studies of various kinds of inserts are needed. They should be developed and implemented with full participation by doctors, pharmacists, consumers, communications experts and the drug industry. Such studies will provide reliable pathways to follow, so that inserts will be useful aids to medical practice.

And particularly we think that you should be closely involved in this debate and in these studies and decisions. Otherwise, people with less experience and qualifications may control the purposes, content and use of a tool with considerable promise for improved patient care. It could make a difference in your practice tomorrow, and more importantly, in the health of your patients.

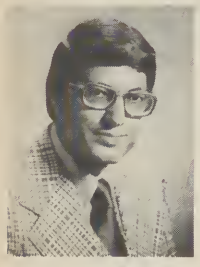
PMA
THE PHARMACEUTICAL MANUFACTURERS ASSOCIATION
1155 FIFTEENTH ST., N. W., WASHINGTON, D. C. 20005

MDs in the news

Leonard S. Dreifus, M.D., Narberth, recently was installed as 27th president of the 8,500-member American College of Cardiology. Dr. Dreifus is chief of cardiovascular diseases at Lankenau Hospital and professor of medicine at Jefferson Medical College.

Dr. Dreifus and **Stanley K. Brockman, M.D.,** professor of surgery and director of the division of cardiothoracic surgery at Jefferson Medical College, recently returned from a 17-day lecture tour of Africa. Sponsored by the U.S. State Department and the American College of Cardiology, the two physicians participated in an educational program on cardiovascular diseases in Nigeria, Kenya, and the Sudan.

Indru T. Khubchandani, M.D., Allentown, has been elected president of the Pennsylvania Society of Colon and Rectal Surgeons. Dr. Khubchandani is president of the medical staff of Allentown and Sacred Heart Hospital Center, associate director general of the International Society of Colon and Rectal Surgeons, and immediate past president of the Lehigh County Medical Society.



Dr. Khubchandani



Dr. Parry

Frazer Parry, M.D., Philadelphia, founding director and senior vice president of Philadelphia's Magee Memorial Rehabilitation Center, recently received the Charles L. Eby Award from the Pennsylvania Rehabilitation Association. The award, named for the former director of the Pennsylvania Bureau for Vocational Rehabilitation, was given for Dr. Parry's years of outstanding contributions in the field of rehabilitation medicine.

Wesley W. Bare, M.D., chairman of obstetrics and gynecology at Methodist Hospital in Philadelphia, recently was featured on the cover of *Parade* magazine for his efforts to raise safety standards for air ambulances. Dr. Bare, founder and president of North American Air Ambulance, is a clinical professor at Jefferson Medical College, a licensed pilot, and a medical examiner for the Federal Aviation Administration.

Francis E. Rosato, M.D., Gladwyne, has been appointed chairman of surgery at Jefferson Medical College, effective August 1. Dr. Rosato, who received his medical training at Hahnemann Medical College, returns to Philadelphia from Norfolk, Virginia where he has been chairman of surgery at Eastern Virginia Medical School.

The Philadelphia Academy of Family Physicians recently elected the following officers: **Stanley Greenwald, M.D.,** president; **Budd E. Axelrod, M.D.,** vice president; **Henry G. Klinges, M.D.,** secretary; and **Eddie Lee Clark, M.D.,** treasurer.

New diplomates of the American Board of Internal Medicine include: **Richard E. Lynn, M.D.,** Connelsville; and **Robert Grunberg, M.D., Mark I. Koshar, M.D., A. Rashid Makhdomi, M.D., Terry R. Pundiak, M.D.,** and **Stanely R. Walker, M.D.,** all of Easton. Other physicians recently certified by their respective specialty boards are: **Murat Bankaci, M.D.,** and **Hussain G. Malik, M.D.,** by the American Board of Otolaryngology; **Mark Rader, M.D.,** and **M.P. Lin, M.D.,** by the American Board of Obstetrics and Gynecology; **Mahendra Matta, M.D., Gerald Morrow, M.D.,** and **Kenneth W. Graf, M.D.,** by the American Board of Surgery; **Wayne Chiavacci, M.D.,** by the American Board of Pediatric Cardiology; and **Charles M. Maas, Jr., M.D.,** by the American Board of Pathology.

Norman N. Cohen, M.D., Philadelphia, chairman of medicine at the Mercy Catholic Medical Center in Darby, has been elected president of the Delaware Valley Society for Gastrointestinal Endoscopy. The society promotes education and research in the field.



Dr. Cohen



Dr. Cox

Paul A. Cox, M.D., of Carlisle, recently received the Distinguished Service Award of the Pennsylvania Academy of Ophthalmology and Otolaryngology for his extensive service in the specialty. A former president of the Academy, Dr. Cox is chairman of the Academy's Ophthalmology Legislative Committee.

Gilbert Grossman, M.D., Jenkintown, has been elected president of the medical staff at Rolling Hill Hospital. A specialist in internal medicine and cardiology, Dr. Grossman is also chairman of the hospital's department of medicine.

Herbert Diamond, M.D., Wynnewood, recently was elected vice president of the National Council of Community Mental Health Centers. Dr. Diamond is medical director of the West Philadelphia Community Mental Health Consortium, Inc., and associate professor of psychiatry at the University of Pennsylvania School of Medicine.

William C. Beck, M.D., president of the Donald Guthrie Foundation for Medical Research and former chairman of surgery at the Robert Packer Hospital and Guthrie Clinic, Sayre, recently was elected president of the Association for the Advancement of Medical Instrumentation.

Office counseling

Evaluating and treating chronic alcoholism

Soroush S. Noori, M.D.
Joseph Adlestein, M.D.

Physicians often are consulted about management of the alcoholic patient, either for the alcoholism itself or for the medical complications resulting from it. This article describes the physician's role in managing the medical aspects of alcoholism, counseling the patient and his family, referring for specialized services, and using community resources.

Chronic alcoholism

Alcoholism is a chronic illness that is psychic, somatic, or psychosomatic, and manifests itself as a disorder of behavior. It is characterized by the repeated drinking of alcoholic beverages to an extent that exceeds customary dietary use or compliance with social customs of the community, and interferes with the drinker's health or his social or economic functioning.[1]

Prevalence—Of the nearly 100 million Americans who drink alcoholic beverages, an estimated nine million suffer from alcoholism. The illness may affect anyone, regardless of social class, vocation, sex, age, race, education, or intelligence. Only 3.5 percent of alcoholics are stereotypes of the "skidrow" variety; the typical alcoholic is employed, married, and living with his family. Although alcoholism is more prevalent in large cities than in rural areas, a physician may encounter alcoholics wherever he practices.

An estimated five of six alcoholics are men between the ages of 35 and 55. Many clinicians believe, however, that alcoholism equally affects men and women. The statistical difference appears because the disease is more visible in men; women are able to remain in their homes and avoid detection. Other statistics indicate that drinking among teenagers is becoming more popular and that teenage alcoholism is a growing problem.

Impact on society—Each year alcoholism costs the nation an estimated $75 billion in lost work time, health and welfare services, property damage, medical expenses, and law enforcement. For each alcoholic, three or four "significant others" suffer from various degrees of emotional and financial stress. According to the National Council on Alcoholism, 64 percent of homicides, 41 percent of assaults, 34 percent of rapes, 30 percent of suicides, and 60 percent of child abuse cases are associated with alcohol consumption. The National Safety Council reports that alcohol consumption is related to more than 50 percent of car accidents fatal to drivers and more than one-third of car accidents fatal to adult pedestrians.

Etiology—According to most investigators in the field, alcoholism results from a complicated interplay of psychological, socio-cultural, and biological factors.

Psychological—Through its effects on the central nervous system, alcohol provides relief from hostility, guilt, tension, and anxiety. It decreases inhibitions, increases the ability to express aggression, and is used commonly as a coping mechanism in dealing with conflicts. The personality structure among alcoholics is as varied as the personality structure in non-alcoholics; the "typical alcoholic personality" is a myth.

Social—Since alcohol is a drug that facilitates social contact, "conforming to the group" is often the rationale for the early stages of drinking. Poverty, social tensions, identification with other members of society, and social group pressures play a role in the manifestation and intensification of alcoholism. Certain occupations present a significant risk for alcoholism, including bartending, commercial traveling, and brewery jobs.

Biological—Evidence strongly indicates biological differences between alcoholics and non-alcoholics. There is also evidence suggesting a familial predisposition to alcoholism.[2]

Dr. Noori is director of the psychiatry consultation and liaison service of the department of psychiatry at the Pennsylvania State University College of Medicine, Hershey. Dr. Adlestein is chief of psychiatry at Harrisburg Hospital and director of emergency psychiatry services at the hospital's mental health/mental retardation center.

Recognizing alcoholism

Early signs of alcoholism are few in number and easily overlooked. During this phase, the physician's most valuable tools are a high index of suspicion and taking a routine "drinking history." In the late phase of illness, the signs are numerous and not likely to be missed.

When taking a history for alcoholism, the physician should be aware that:

- More than 70 percent of the adult population drinks on a regular basis.
- Most alcoholics live with their families and superficially do not differ from non-alcoholics.
- An alcoholic patient has a strong

TABLE 1
Signs of Alcoholism
(Adapted from Seliger, R.V., M.D.[3])

1. Do you need a drink at a definite time every day?
2. Do you prefer drinking alone?
3. Do you find yourself getting drunk every time you drink?
4. When you drink, do you have loss of memory or blackouts?
5. Do you have the shakes after drinking?
6. Do you get the inner shakes unless you continue drinking?
7. Do you hide or sneak your drinks?
8. Do you have mid-week or weekend drunks?
9. Do you crave a drink in the morning?
10. Has drinking made you careless of your family's welfare?
11. Do you show marked moodiness as a result of drinking?
12. Is it jeopardizing your job, business, or career?
13. Has it made you irritable or belligerent?
14. Do you become argumentative when drinking?
15. Is it making your home life unhappy?
16. While drinking are you restless in your sleep?
17. Do you drink to relieve feelings of inadequacy?
18. Has drinking made you harder to get along with?
19. While drinking, have you become extravagant in behavior?
20. Has your drinking pattern changed?
21. Have you lost any friends or any job as a result of drinking?
22. Do you continually seek occasions for drinking?

TABLE 2
Suggestions for Families of Alcoholics
(Adapted[4])

DOs	*DON'Ts*
1. Learn the facts about alcoholism. Attend meetings of AA and Al-Anon family groups.	1. Don't preach, nag, lecture, or assume a "holier-than-thou" attitude.
2. Develop a positive attitude to match the facts.	2. Never use emotional appeals like "If you loved me"—they increase feelings of guilt and the compulsive need to drink.
3. Test your attitude toward alcoholism by taking honest, personal inventory of yourself.	3. Don't make threats you won't carry out.
4. Discuss the situation with someone you trust; if possible, a person who has experienced some phase of alcoholism.	4. Don't see the alcoholic as a moral weakling or take over his responsibilities, leaving him with no sense of importance or value.
5. Abstain from alcohol.	5. Don't shelter the alcoholic from situations in which alcohol is present; don't hide bottles or pour liquor down the drain.
6. Establish and maintain a healthy atmosphere in the home, with a sympathetic place in the family circle for the alcoholic member.	6. Never extract promises or place the alcoholic in a position in which he must be deceitful.
7. Encourage new interests and participate whenever possible in recreational or occupational activities; encourage him to see old friends.	7. Don't argue or put pressure on the alcoholic when he is drinking or intoxicated.
8. Be patient and live one day at a time: recovery doesn't happen overnight. Accept setbacks and relapses with equanimity.	8. Never be overconfident or expect a recovery that is either immediate or complete.
9. Approach the alcoholic about his drinking problem but only when he is sober.	9. Don't cover up or make excuses for the alcoholic.
10. Discreetly place injurious objects out of sight, and attempt to withhold car keys when the alcoholic becomes intoxicated.	10. Try not to be a martyr, feel ashamed or at fault. These attitudes destroy objectivity.
11. Explain the nature of alcoholism as an illness to children in the family; try to spare their seeing the alcoholic parent in an extremely intoxicated state.	11. Avoid passing judgment on the method of recovery selected by the alcoholic.
12. Advise local bartenders and police, whenever possible, about the alcoholic's condition to help prevent community incidents and embarrassments.	12. Never use the children as tools or turn them against the alcoholic.

tendency to deny drinking problems and to rationalize drinking.

• Most alcoholics and non-alcoholics call themselves "social drinkers." It is important to determine exactly how much the patient drinks, how often he drinks, and the largest amount that he occasionally drinks. If answers to these questions suggest a drinking problem, the physician specifically asks about effects of the patient's drinking on his job, family, and social adjustment. Table 1 lists questions that may confirm the diagnosis of alcoholism.

• Fear of offending a patient does not justify avoidance of proper evaluation and treatment of any illness.

When taking a history, the physician may note the following warning signs of alcoholism:

1. Frequent drinking sprees and an increase in tolerance to alcohol.
2. Solitary drinking (to relieve anxiety, depression, or other symptoms) and a tendency to make excuses for drinking.
3. Taking extra drinks before parties, drinking before coming home, or drinking during the day.
4. Avoiding any reference to drinking, or lying about consumption of alcohol.
5. Frequent absenteeism from the job, a decline in job status, and recurring problems with the job.
6. Frequent family and marital problems.
7. A decline in social status and a history of arrests for drunken driving or other alcohol-related offenses.

On physical examination of the patient, the following signs may indicate a diagnosis of alcoholism:

1. Odor of alcohol on breath at time of medical appointment.
2. Tachycardia, flushed face, and nocturnal diaphoresis.
3. Coarse and unexplained hand tremor.
4. Alcoholic facies, vascular engorgement of the face, and red nose.
5. Ecchymosis on the lower extremities, arms, or chest.
6. Cigarette or other burns on the hands or chest.
7. Dehydration and nutritional deficiency.
8. Increased incidence of infection.
9. Persistent gastric or duodenal ulcer, pancreatitis, or cirrhosis of the liver.
10. Peripheral neuropathy.
11. Evidence of forgetfulness, emotional lability, and other features of organic brain syndrome.

Managing the alcoholic

Medical complications—The life expectancy for alcoholics is 10 to 12 years less than average. No organ system is safe from the chronic, heavy use of alcohol. In the gastrointestinal tract, liver damage is the most serious problem, followed by bleeding, gastric ulcer, gastritis, and diarrhea. Chronic alcoholics may also develop cardiomyopathy, myopathy, thrombocytopenia, and anemia. Amblyopia may be an effect of retrobulbar neuropathy (tobacco-alcohol amblyopia). Another important nervous system disease is the Wernicke-Korsakoff syndrome, of which confabulation and short-term memory loss are the most significant features.

Delirium tremens (DTs) may occur during complete or relative abstinence from ethanol. The most common withdrawal symptom is tremor followed by confusion, psychotic manifestations, and clouding of the sensorium. Finally, alcoholic hallucinosis and suicide can be secondary to the chronic use of alcohol.

Complete medical evaluation and treatment of all medical complications is essential.

Treating anxiety—When treating chronic alcoholism, anti-anxiety agents should be used with great caution. These drugs generally do not improve the patient's potential for rehabilitation and may lead to new or additional forms of drug dependence. All anti-anxiety drugs potentiate the effect of ethanol, and most result in cross addiction. In a minority of patients suffering from severe, generalized, persistent (free floating) anxiety, however, there may be benefit from the limited use of anti-anxiety drugs. Among these drugs the long-acting benzodiazepines, such as diazepam or chlordiazepoxide, are better choices because tolerance is less of a problem, and when used alone the suicide risk is not high.

Treating depression—Patients who drink because they are endogenously or reactively depressed frequently benefit from tricyclic antidepressants and/or psychotherapy. The physician should evaluate and treat these patients or refer them for psychiatric treatment.

Use of Disulfiram—Certain patients benefit from Disulfiram, a pharmacologic deterrant to drinking. It can be used as a major adjunct in the treatment of the well-motivated alcoholic who at times has an impulsive craving for alcohol. Disulfiram should never be administered to a patient who is intoxicated.

Following alcohol ingestion, this drug blocks aldehyde dehydrogenase, which results in an accumulation of acetaldehyde. Markedly unpleasant symptoms, such as flushing of the face, a feeling of constriction in the neck, spasms of coughing, and labored breathing are experienced. With consumption of larger amounts of alcohol, the patient soon feels nauseated and begins to vomit, flushing is replaced by pallor, and the patient becomes hypotensive.

Disulfiram has a long duration of action (an average of four days) even after it is discontinued. Most patients can be maintained on a daily dose of 125 to 500 mg.

The patient and his family should be instructed about the drug and its interaction with alcohol, and the patient also should carry an identification card stating that he is under treatment with Disulfiram. The card should indicate the name of the physician and/or institution to be contacted in an emergency.

Disulfiram is contraindicated in patients with a history of heart disease or psychosis, and it is used cautiously with many other drugs in order to avoid drug interaction. Before prescribing the drug, the physician should familiarize himself with the indications, contraindications, and side effects of Disulfiram.

Counseling the alcoholic

A small number of alcoholics suffer from major emotional disorders that require treatment by a psychiatrist.

The majority of alcoholics can be treated by the primary care physician, especially if he has made the diagnosis and has offered medical treatment. The physician can use such familiar counseling skills as careful listening, problem identification, clarification, education, guidance, and reassurance.

Goals of counseling—The physician may accomplish several important objectives with the effective use of office counseling:

- Establish that drinking can be discussed and assist the patient in recognizing that he is an alcoholic and needs treatment. Especially important is a nonjudgmental, empathetic approach and unconditional positive regard.
- Gain the patient's agreement to abstain from alcohol. Abstinence is essential to recovery, even in the face of the severe physical and emotional discomfort accompanying its early stages. Furthermore, sobriety is critical for accurate evaluation of possible coexisting psychiatric disorders. With the help of the physician's counseling at first, and later independently, the patient should become able to cope with problems without the use of alcohol.
- Assist the patient in coping with stresses of living in ways other than through the use of alcohol. Many alcoholics use alcohol to submerge unwanted feelings. The physician can help to identify these feelings and guide the patient to the development of alternative coping mechanisms.

Counseling the family—Alcoholism, like many other chronic illnesses, has a profound impact on the patient's family. A positive attitude by family members can help the patient enter and remain in treatment; a negative attitude will perpetuate the drinking problem. The treatment process can be facilitated by careful evaluation of the relationship between the patient and spouse or family, particularly in a joint interview.

A patient who enters treatment and tries to avoid drinking may become irritable and depressed. The physician can prepare the family for this difficult but expected transient period and encourage discussion of reactions and feelings. Table 2 contains some helpful advice for family members of alcoholics.

Referring the alcoholic

In managing the alcoholic patient, the physician often must use community resources as the principle source of treatment or as a significant adjunct to his own treatment. A list of these resources follows.

1. *Local government programs:* Each county in Pennsylvania has a mandated program, operated as a separate program for alcohol and drug abuse or as a part of the local community mental health/mental retardation program, which can provide comprehensive treatment planning and services.

2. *Detoxification centers:* These facilities are concerned with the detoxification process and with providing immediate services to intoxicated individuals. The centers allow detoxification in a therapeutic milieu rather than in jail and referral to appropriate therapeutic resources in the community.

3. *Halfway houses:* Many patients may quickly resume drinking if they have no place to go after detoxification. A halfway facility works with the patient for an extended period and provides shelter, counseling, and referral to vocational rehabilitation, Alcoholics Anonymous, etc.

4. *Specialized private facilities:* Throughout the state there is a network of private rehabilitation programs offering voluntary residential treatment extending over a period of 30 to 90 days. In many instances, these centers operate as a part of the county program or as a private facility.

5. *Alcoholics Anonymous (AA):* Chapters of this organization are available in most communities. The goal of AA is to help its members to help each other. Most local groups are listed in the telephone book. For additional information, physicians can subscribe to AA's publication, "Grapevine."

6. *AL-ANON and AL-ATEEN:* These organizations are designed to help the non-alcoholic members of the alcoholic's family share experiences and increase knowledge and understanding of themselves and the alcoholic.

Many other organizations, such as church groups and local chapters of the National Council on Alcoholism, offer information and active educational programs for alcoholics and their family members. For specific information concerning programs and services in any area, the physician may contact the local county alcoholism program or the Governor's Council on Drug and Alcohol Abuse.

Treatment guidelines

When counseling and treating alcoholics, the physician should remember that:

- Alcoholism is a chronic illness, and relapses are characteristic.
- Many alcoholics are demanding and unrealistic: they often challenge the physician's ability to maintain a therapeutic relationship by displaying traits of egocentricity, paranoia, ambivalence, lack of insight, arrogance, defiance, and moods of despair.
- Frustrating and serious social, vocational, and family problems frequently coexist. Thus the physician should become familiar with appropriate community agencies and use their resources in managing the patient.
- Heavy drinking is sometimes symptomatic of major psychiatric illnesses, such as schizophrenia, manic-depressive illness, severe endogenous depression, and involutional melancholia, where large amounts of alcohol are consumed as self medication. Symptoms of severe depression, suicidal ideation, elated unstable moods, hyperactivity, looseness of associations, hallucinations, inappropriate affect, or repetitive outbursts of rage with or without alcohol consumption alert the physician to the possibility of an underlying emotional illness. The physician then can refer these patients to psychiatric facilities in their community for consultation and/or treatment. □

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Case report

Tuberculous-like disease produced by *M. scrofulaceum*

Kent R. Aikin, M.D.
Robert F. Johnston, M.D.

Mycobacterium scrofulaceum is a scotochromogenic acid-alcohol-fast bacillus belonging to Group II of the Runyon mycobacterial classification. The term "scrofulaceum" was first used by Prissick and Masson[1] to describe the organism isolated largely from infected lymph nodes, or scrofula, in children. This name has been accepted generally and replaces the earlier nomenclature, *M. marianum,* proposed by Penso.[2,3]

Most commonly associated with childhood adenitis, *M. scrofulaceum* also has been reported as the etiologic agent in a variety of other infections. In particular, pulmonary disease due to this organism is of increasing importance in Pennsylvania. Recent epidemiologic data show that *M. scrofulaceum* is a mycobacterium other than tuberculosis (MOTT) frequently isolated from patients' sputum in this state. The presented case is that of a Bucks County resident with pulmonary disease due to *M. scrofulaceum.*

Case report

The patient, a 52-year-old male, was first admitted to the hospital in December 1973 because of hemoptysis. Skin test for tuberculin (PPD-T) was negative with 2 mm of induration. Sputum smears were negative, but sputum cultures at that time were positive for acid-fast bacilli.

On January 15, 1974, he started treatment with isoniazid 300 mg daily and ethambutol 1200 mg daily. The organism isolated from his sputum was later identified as *Mycobacterium scrofulaceum,* which was sensitive to isoniazid 1 mcg and rifampin 1 and 5 mcg, but moderately resistant to PAS 5 mcg, streptomycin 5 mcg, and ethambutol 10 mcg. He was maintained on the drug therapy and his chest x-ray showed some improvement. Sputum smears continued to be negative, but *M. scrofulaceum* was isolated from sputum cultures in April 1974, February 1975, and April 1975. Also, two sputum cultures done in May 1974 were positive for *M. intracellulare.*

Bronchoscopy was performed in July 1975. Blood was seen coming from the posterior apical segment of the left upper lobe, but no specific bleeding source was identified.

The patient remained asymptomatic and his condition was regarded as stable. A total of seven sputum cultures obtained between October 1975 and February 1976 were positive for *M. scrofulaceum.* A Group III mycobacterium was isolated from three sputum cultures in early 1976 and Group IV *M. fortuitum* was identified from a sputum culture in May 1976. The stability of the patient's clinical condition and chest x-rays prompted discontinuing the isoniazid and ethambutol therapy on August 25, 1976.

Dr. Johnston is director of the division of pulmonary diseases and professor of medicine at Hahnemann Medical College and Hospital, Philadelphia. Dr. Aikin, currently serving a family practice residency in Colorado, was associated with Hahnemann at the time this paper was written.

On December 17, 1976, the patient was re-admitted to the hospital with complaints of night sweats, increased sputum production with occasional hemoptysis, some left-sided pleuritic chest pain, and a generalized feeling of weakness. Pertinent history obtained at the time of admission included cigarette smoking, two packs daily for the past thirty years. He had lived exclusively in the Philadelphia area and travel history was negative. For the past fourteen years he worked as a laborer in a steel mill, where he sometimes was assigned to burning defects from the surface of steel slabs, a job which exposed him to concentrated dust inhalation.

On examination he appeared well-developed, slightly cachectic, and in no acute distress. The temperature was 99.8° F. No lymphadenopathy was found. The lungs were clear to percussion; ronchi at the right base and a few expiratory wheezes at the left apex were noted. There was a question of minimal clubbing of the fingers. No cyanosis was noted.

Initial laboratory studies showed a hemoglobin of 13.1 g with a hematocrit of 39.6 percent. The white cell count was 7,700 with 70 percent neutrophils, 6 percent band forms, 1 percent eosinophils, and 19 percent lymphocytes. Pulmonary function studies showed a moderate obstructive pattern with hyperinflation, but this test's validity was questionable because of the patient's possible suboptimal effort. Skin test for tuberculin (PPD-T) was positive at 20 mm.



Figure 1A. Chest roentgenograph taken at time of diagnosis shows dense left upper lobe infiltration and stranding in right apex.



Figure 1B. Chest roentgenograph taken after six months of chemotherapy shows clearing of much of the left upper lobe disease but a cavity shadow persists in the left anterior first interspace. There is no change in the right upper lobe disease.



Figure 1C. Chest roentgenograph shows spread of disease through the superior division of the left upper lobe in the inferior division (lingula) and to the superior segment of the left lower lobe. An oval shaped cavity is present beneath the medial end of the left clavicle. There has been no definite change in right upper lobe disease.

Sputum smears obtained on admission were positive for acid-fast bacilli, and the patient was started on chemotherapy in an attempt to control his disease. The treatment included: ethionamide, 1 g daily; rifampin, 600 mg daily; pyrazinamide, 3 g daily; and streptomycin, 1 g daily for five days a week. The symptomatology gradually improved and the patient's temperature decreased to normal during his hospital stay.

The earliest chest roentgenogram from December 1973 showed a pneumonic infiltrate in the left upper lobe extending in a dense band from the left upper hilum to the left lateral chest wall. There was also a less prominent infiltrate in the right apex. A radiograph taken in July 1974 showed resolution of the left upper lobe infiltrate with formation of a cavity in that area. X-rays in October 1975 and April 1976 again showed a left upper lobe cavity, but otherwise were the same. Two months following cessation of the isoniazid and ethambutol therapy, an x-ray showed a new pneumonic infiltrate in the left apex with continued presence of the thick-walled left upper lobe cavitation.

On admission to the hospital in December 1976, the chest radiograph revealed further increase in the density and area of the left upper lobe infiltrate with extension into the lingula. On January 14, 1977 at the time of discharge, some probable slight resolution of the infiltrate was observed. This was after nearly four weeks of therapy with the new drug regimen.

On the basis of the isolation of *M. scrofulaceum* from 11 of 17 positive cultures, that organism is considered responsible for the infection in this case. The relative infrequency of this diagnosis warrants a discussion of this mycobacterium and its role in human pulmonary disease.

Discussion

The pathogenicity of *M. scrofulaceum* for both man and laboratory animals has been demonstrated. A study by Demoulin-Brahy[4] showed that inoculation of rabbits and mice produced morbidity and mortality in both animals, especially the rabbits. Guinea pigs were relatively resistant to infection.

In man, the organism has classically been associated with childhood adenitis. Hauduroy[5] identified 48 of 51 strains of mycobacterium isolated from infected lymph nodes as *M. scrofulaceum*.

Reviewing the literature also reveals cases of skin and soft tissue infections,[5-7] Potts disease,[8] and overwhelming systemic infection.[9,10] The latter has usually been reported in the debilitated host, but Korsak[10] described an eleven year old girl in whom no immune deficiency was identified and who at autopsy had lesions of skin, gastrointestinal tract, lungs, lymph nodes, and bones from which *M. scrofulaceum* was cultured. This patient survived four years and even showed improvement on a varied chemotherapeutic regimen, but succumbed to presumably drug-induced cholestatic hepatitis.

Pulmonary *M. scrofulaceum* infections also have been reported.[4] These occur predominantly in adults, but at least one case has been described in a child.[11] An analysis of MOTT pulmonary disease in Japan[12] associated long-term exposure to dust or the presence of pneumoconiosis with infection in 59 percent of cases caused by scotochromogens, whereas these factors were noted in only 14.4 percent of the cases caused by nonphotochromogenic mycobacteria.

Interestingly, Wolinsky[13] reported scotochromogen pulmonary infection in four men whose occupational dust exposures were similar to that of the case reported here. Two were welders, one a grinder, and the fourth an acetylene cutter and grinder; all were in their fifth decade and all failed to respond adequately to chemotherapy with PAS, streptomycin, and isoniazid.

The source of *M. scrofulaceum* for human pulmonary disease must be

questioned. The organism has been isolated from soil, water,[14] and house dust. Reznikov *et al.*[15] found that 12 *M. intracellulare-M. scrofulaceum* serotypes cultured from house dust were identical to 53 percent of the strains from sputum of patients with radiographic evidence of pulmonary infection who lived in the area where the dust was collected.

The mouth and upper respiratory tract may be the portal of entry, and the isolation of Group II mycobacteria from expectorated sputum, bronchial washings, and gastric lavage supports this possibility. However, Warring[16] has cautioned that these organisms may be mere contaminants in the specimen collection. Wolinsky and Rynearson[17] reported *M. scrofulaceum* as the etiologic agent in the majority of pulmonary and lymph node infections that they studied, but the organism was isolated in only 10 percent of positive soil cultures—evidence emphasizing the need for further analysis of the source of *scrofulaceum* disease.

The diagnosis of *M. scrofulaceum* pulmonary disease is made by identification of the organism in cultures of specimens obtained from a patient with a MOTT pulmonary infection. Several authors have proposed criteria for the diagnosis of MOTT disease.[18,19] In the case presented here, the diagnosis was based on the criteria used by Bates:[20]

> (1) Parenchymal pulmonary disease was demonstrated in chest roentgenogram, (2) mycobacteria other than *M. tuberculosis* were cultured from sputum, pleural fluid, or tissue on two or more occasions, and (3) the mycobacteria thus isolated were considered by the clinician in charge of the patient to be the cause of the disease.

Skin test antigens may be of value in differentiating tuberculosis from MOTT infections when PPD-T and other mycobacterial antigens are used concurrently. Due to frequent cross-reactions to the MOTT antigen preparations, however, they cannot be used for specific diagnosis.[21]

Therapeutic management

Once the diagnosis has been made, therapy poses yet another difficult question. According to Boisvert,[22] *M. scrofulaceum* is always sensitive to cycloserine; variably sensitive to ethionamide, ethambutol, and rifampin; usually resistant to streptomycin and kanamycin; and always resistant to isoniazid, PAS, and viomycin. Prolonged therapy with these and other drugs often fails to produce more than temporary clinical improvement. Drug resistance of *M. scrofulaceum* tends to be high, and usually increases during treatment even with combination chemotherapy.

Korsak[10] isolated L-forms of *M. scrofulaceum* from biopsy and autopsy specimens of the patient he reported, which raises the possibility of their role in the pathogenesis and drug resistance of this infection. The exact mechanism of action against mycobacteria is not clearly defined for all commonly used drugs, but cycloserine and kanamycin are thought to inhibit cell wall synthesis or damage the cell wall or membrane. Thus L-forms could be less susceptible to these drugs.

When chemotherapy produces radiographic improvement and sputum conversion occurs or the number of organisms excreted diminishes, resection should be considered if the disease is of limited extent. With limited disease, resection should be considered even if the response to chemotherapy is equivocal; operating in the presence of positive sputum has been successful in this infection which is less virulent than tuberculosis. Yamamoto *et al.*[12] reported successful management in 9 of 10 patients with scotochromogenic infection who underwent segmental resection. Two of the four patients in Wolinsky's series were free of recurrent disease four years post-lobectomy.

It seems reasonable that therapeutic mangement should begin with combination chemotherapy, optimally based on the results of drug susceptibility studies of the cultured organisms. Resectional surgery should be used more aggressively than it is with tuberculosis. Patients need not be isolated, even if sputum smears remain positive for acid-fast bacilli. Person-to-person transmission of *M. scrofulaceum* pulmonary infection has not been shown to occur.

Epidemiologic data for Pennsylvania[23] (Table 1) show that *M. scrofulaceum* is identified by sputum culture. From 1973 to 1975, *M. scrofulaceum* was isolated from an annual mean of 42.2 percent of those patients with cultures that were positive for either this organism or *M. kansasii, M. fortuitum,* or Group III organisms. While the occurrence of actual pulmonary disease is uncertain, the data indicate the potential clinical importance of *M. scrofulaceum.* Furthermore, the declining incidence of tuberculosis magnifies the problem posed by this highly drug-resistant organism.

In summary, *M. scrofulaceum* is a scotochromogenic organism with distinct microbacteriologic characteristics. Its ability to produce human disease, such as the pulmonary infection reported here, is well known. The organism's mechanisms of pathogenicity and drug resistance remain uncertain, and further research, including better definition of the source of infection and the role of L-forms, is warranted. Meanwhile, combined chemotherapy with surgical resection when indicated remains the therapeutic approach to this pulmonary disease. □

TABLE 1
Number of Patients with Sputum Cultures Positive for Atypical Mycobacteria in Pennsylvania[28]

	M. kansasii	*M. scrofulaceum*	*Group III*	*M. fortuitum*	*Total*
1973	21	113	71	19	224
1974	17	96	83	25	221
1975	22	60	93	19	194
Average 1973-75	20	89.7	82.3	21	213

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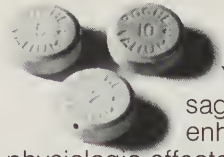
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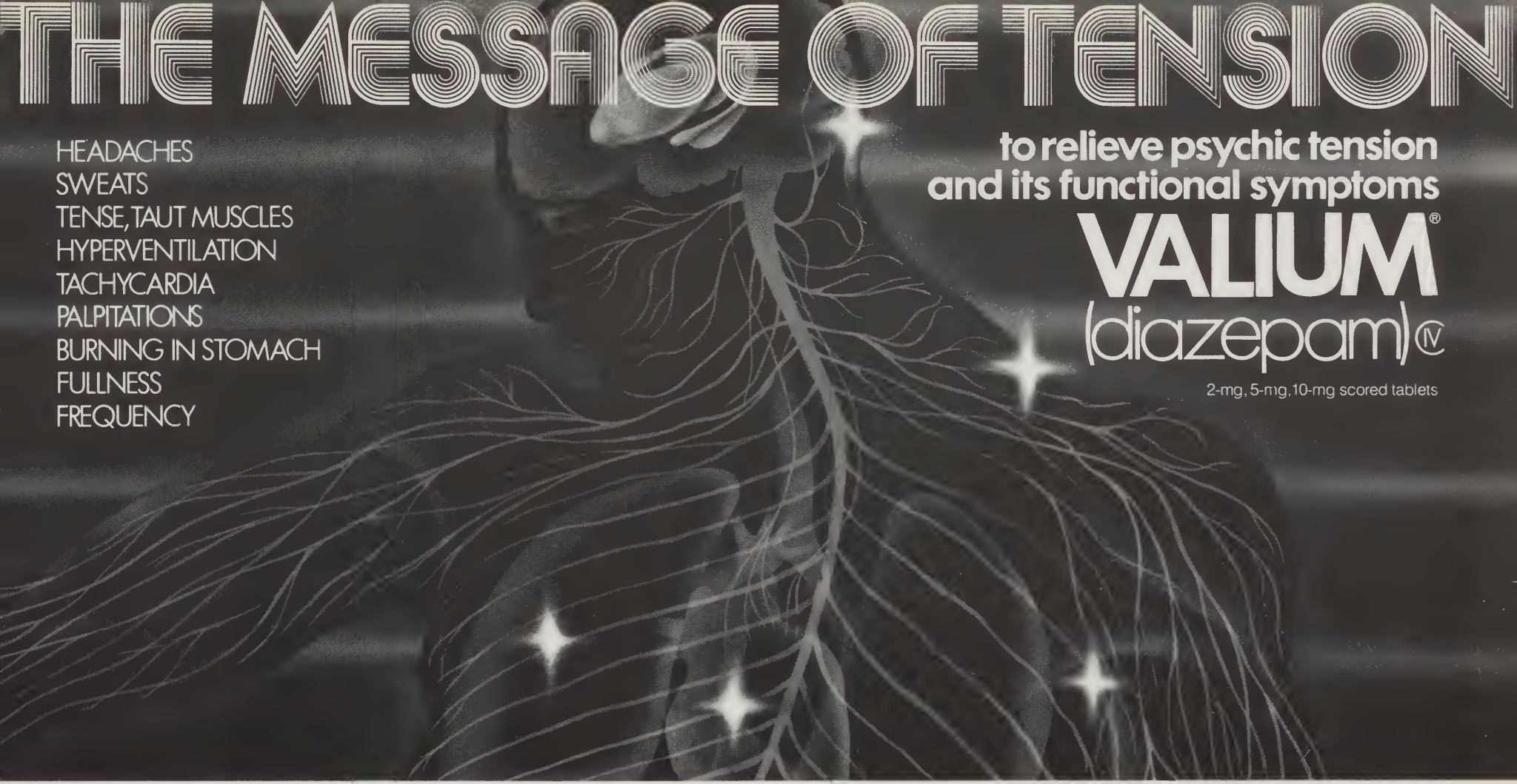
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The effectiveness of Valium in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

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Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**
Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.
Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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STATE MEDICAL BOARD TO CERTIFY ASSISTANTS

The State Board of Medical Education and Licensure will certify and control the activities of Physicians' Assistants under legislation signed into law by Governor Milton J. Shapp. Act 79 of 1978 becomes effective January 1, 1979. The state medical board already has a working draft of rules and regulations and expects to have them ready for publication after the board's September meeting.

COMMITTEE ON IMPAIRED PHYSICIAN APPOINTED

George A. Rowland, M.D., chairman of the Board of Trustees, has appointed the following physicians to the new Committee on Impaired Physicians: Betty L. Cottle, M.D., Altoona; Allen J. Kogan, M.D., Philadelphia; Edward J. Resnick, M.D., Philadelphia; Alfred P. Trescott, M.D., Wellsboro; and Abraham J. Twerski, M.D., chairman, Pittsburgh. A confidential telephone system with a special taping device takes messages directly from callers to physicians on the committee. The telephone number is 717-763-7937.

GOVERNOR SIGNS BILL AMENDING WORKMEN'S COMP

H.B. 711, amending the Workmen's Compensation Act, was signed into law by the governor in July. For the first time employes of businesses which have employer appointed panels of physicians will be permitted to be treated by their personal doctors after 14 days of treatment by a member of management's panel. Also for the first time, employers may name chiropractors to the panels. Chiropractors opposed the bill because, as a result of a court decision last year, injured workers wishing to consult a chiropractor could do so and be compensated even if there were an employer appointed panel since the law did not permit the appointment of "other duly licensed practitioners" to the panels. The Act becomes effective September 1, 1978.

STATE MEDICAL BOARD STAFFING CONTINUES

The State Board of Medical Education and Licensure has announced the selection of seven attorneys who will act as hearing officers for the board. They are James H. Rowland, Sr., and Isadore Kranzel, Harrisburg; Daniel Segal, Garnita Selby, and Louis E. Seltzer, Philadelphia; and Richard T. Wently and Joy Conti, Pittsburgh. The Board has three full time attorneys, one as general counsel and two as prosecutors. Twelve medical investigators who recently completed a special training program at Shippensburg State College are in the field collecting data on a two-year backlog of complaints received by the medical board. All of this activity occurred after PMS filed suit against the state for failing to enforce the new Medical Practice Act.

CARTER SIGNS LAW ON HOME DIALYSIS

President Carter has signed legislation permitting federal reimbursement for kidney dialysis performed at home as well as in hospitals and dialysis centers. Previously only medical center dialysis was covered by federal programs. The State Society has long advocated home dialysis reimbursement.

COST COMMITTEE ANNOUNCES WORK PLAN FOR STATE

The Pennsylvania Voluntary Health Care Cost Containment Committee (PAVE) unveiled its work plan for cost containment July 19. The plan calls for at least a two percent reduction in the annual rate of increase in Pennsylvania hospitals' aggregate expenditures during the fiscal year which ends June 30, 1979. The voluntary cost containment effort in Pennsylvania is part of the national Voluntary Effort program launched by the American Hospital Association, the American Medical Association, and the Federation of American Hospitals.

WELFARE DEPARTMENT'S PLAN ON COSTS EFFECTIVE JULY 1

The Department of Public Welfare put into effect July 1, 1978, the Shapp administration's plan to keep hospital cost increases to within 12 percent in the 1978-79 fiscal year. Public Welfare Secretary Aldo Colautti announced the effective date after Governor Shapp vetoed S.B. 292, which was amended in the legislature specifically to prevent the welfare department from promulgating regulations limiting the state's payments to hospitals for the care of Medical Assistance patients. The legislature is in recess until September, but it is expected to consider a bill to override the veto at that time.

COMMITTEE ON MA PROGRAM TO BEGIN QUALITY REVIEW

An Ad Hoc Committee on Medical Assistance Program Improvement Project (MAPIP) was recently named by PMS Board Chairman George Rowland, M.D. The committee will analyze the state medical assistance program and develop recommendations to improve administration, financing, and quality control. Committee members are: Chairman Henry H. Fetterman, M.D., Allentown; Paul F. Kase, M.D., Harrisburg; George R. Fisher, III, M.D., and Bernard Zamostien, M.D., both of Philadelphia; A. Linn Weigel, M.D., Pittsburgh; James C. Miller, D.O., Pennsylvania Osteopathic Medical Association; Claude E. Nichols, M.D., Keystone Medical Society; and O. K. Stephenson M.D., Department of Public Welfare.

TWENTY-THIRD ANNUAL PMGA TOURNAMENT will be held September 11, 1978, at the Toftrees Country Club, State College, Pennsylvania. Complete package for $70 (non-PMGA members add $5.00 one-time membership fee). Includes buffet luncheon, greens fee, cart, hors d'oeuvres dinner, gratuities, flight prize, door prizes.

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Pennsylvania Medicine

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Board approves new council on socioeconomics

The State Society Board of Trustees on May 17 approved changes in the accountabilities of councils and formation of a new administrative council to handle socioeconomic issues. The fifth council, designated the Council on Health Planning and Facilities, is accountable for problems of hospital health care delivery, including services to hospital medical staffs, long term care, health planning (health systems agencies), and health care costs.

Formation of the new council was recommended by the Ad Hoc Committee to Study Society Structure to relieve the "overwhelming" accountabilities of the Council on Medical Service. That council, now designated the Council on Medical Economics, retains responsibility for professional liability insurance, relations with third party payers, the state's medical assistance program, and the Pennsylvania medical care program (peer review committees).

Several additional recommendations changing the accountabilities of councils were approved by the Board. The Commission on Health Planning will function under the new Council on Health Planning and Facilities. All insurance benefits programs for members with the exception of professional liability insurance will be administered under the Council on Member Services (formerly Professional Relations and Services). Also renamed is the Council on Legislation (formerly Governmental Relations). The Council on Education and Science remains the same.

Members of the Council on Health Planning and Facilities are: Paul F. Kase, M.D. (Dauphin), chairman; Henry H. Fetterman, M.D. (Lehigh), vice chairman;

Also, Joseph V. Caliguiri, M.D. (Allegheny); Betty L. Cottle, M.D. (Blair); George R. Fisher, III, M.D. (Philadelphia); Webb S. Hersperger, M.D. (Cumberland); George W. Katter, M.D. (Cambria); John R. Mazero, M.D. (Westmoreland); John P. Mraz, M.D. (Erie); Robert Poole, III, M.D. (Chester); Robert M. Pilewski, M.D. (Venango); Ray G. Sarver, M.D. (Westmoreland); Robert D. Snyder, M.D. (Montour); John L. Steigerwalt, M.D. (Montgomery).



The Pennsylvania Delegation to the AMA caucused early each morning during the AMA meeting in St. Louis. Above, R. Robert Tyson, M.D., who was appointed to the AMA Council on Continuing Physician Education at the St. Louis meeting, speaks to his fellow delegates. John B. Lovette, M.D., of Johnstown, is chairman of the Pennsylvania Delegation.

Genetic counseling films available

"Bioethics in Genetic Counseling," a series of three slide tape programs, is now available from the Pennsylvania Medical Society. Each 20-minute film is designed to stimulate discussion of the major ethical considerations faced by physicians when counseling patients on abortion, amniocentesis, genetic screening, sterilization, or artificial insemination.

Supported by a grant from the Pennsylvania Medical Society's Commission on Medicine, Religion and Bioethics, the presentations were prepared by Garrett E. Bergman, M.D., and John H. Sorenson, Th.M., M.S.W., codirectors of the teaching program in human values in medicine at the Medical College of Pennsylvania, Philadelphia.

The films are available free to all county medical societies. Medical schools, hospitals, theological seminaries, and out-of-state medical societies will be charged $5 for postage and handling. Each slide tape presentation may be purchased for $50; $150 for the entire series. For more information contact the Director of Educational Activities, Pennsylvania Medical Society, 20 Erford Rd., Lemoyne, PA 17043.



George A. Rowland, M.D., Millville family physician, was elected to the AMA Board of Trustees at the St. Louis meeting of the House of Delegates. Dr. Rowland currently serves as chairman of the PMS Board. William Y. Rial, M.D., of Swarthmore, was re-elected speaker of the AMA House of Delegates at the meeting.

Pennsylvania schools graduate 1046 M.D.s

Some 1046 new M.D.s graduated from Pennsylvania's seven medical schools in 1978, an increase of 27 over 1977. A summary of each school's commencement exercises is given below.

Hahnemann Medical College

Sixteen of the 162 men and women who received medical degrees from Hahnemann Medical College June 1 are the first graduates of the school's special program to prepare primary care physicians to practice in medically underserved areas of Pennsylvania. Earlier this year they received baccalaureate degrees from Wilkes College, Wilkes-Barre.

It appears that more than half of this first MD/Pa class are committed to serving northeastern Pennsylvania and that more than three-quarters will become primary care physicians.

Jefferson Medical College

The 154th commencement exercises of Jefferson Medical College on June 9 saw the awarding of medical degrees to 230 graduates, more than half of whom are Pennsylvania residents. William F. Kellow, M.D., dean and vice president, presented diplomas to graduates.

MCP

June 3 commencement exercises at the Medical College of Pennsylvania saw the awarding of medical degrees to 105 graduates by Robert E. Cooke, M.D., MCP president. Edithe J. Levit, M.D., president of the National Board of Medical Examiners and an alumna of MCP, gave the commencement address.

Pennsylvania State University

The Pennsylvania State University College of Medicine at the Milton S. Hershey Medical Center passed the 500 mark in M.D. degrees and the 600 mark in total degrees awarded at the school's eighth commencement ceremonies May 20.

Eighty-four new physicians raised the total of M.D. degrees awarded at Pennsylvania's newest medical school to 511.

University of Pittsburgh

The University of Pittsburgh School of Medicine held commencement exercises May 25 at Carnegie Music Hall. Medical degrees were conferred on 133 graduating seniors by Gerhard Werner, M.D., dean of the school of medicine, and Frances L. Drew, M.D., associate dean for student affairs.

University of Pennsylvania

The University of Pennsylvania School of Medicine awarded medical degrees to 108 men and 46 women during ceremonies May 22 at the Civic Center auditorium.

Edward J. Stemmler, M.D., dean of the school, gave opening remarks and awarded diplomas and prizes. Farewell remarks were given by Jonathan E. Rhoads, M.D., professor of surgery.

Temple University

The largest single group of minority students to graduate from a Pennsylvania medical school received degrees May 25 from Temple University School of Medicine. The school conferred degrees on 27 students from minority backgrounds, 21 of whom will enter primary care specialties.

The graduating class of 178 includes 43 women. Of the graduates 98 will serve residencies in Pennsylvania, 67 in other parts of the United States, and 11 in military or public health.

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Commonwealth Court narrowly construes Act III purpose

Fred Speaker, Esq.

Act 111[1] has now reached the Commonwealth Court and has received its first decision. The case specifically involves the extent of authority under the Act to reach non-health care providers. It began in a rather routine way—a snowball fight between two brothers. One brother was struck on the side of the head by a snowball and early the next morning awoke with head pains and began vomiting. His parents rushed him to an emergency room where his condition deteriorated, and that evening he lapsed into unconsciousness and later died.

Later in the year the boy's parents began arbitration proceedings under Act 111 against the health care center, the professional association staffing the emergency room facilities, and Dr. Gillette. Dr. Gillette filed a complaint to join the surviving brother as an additional defendant, stating that his act of throwing the snowball was the sole cause of his brother's death. Preliminary objections were filed against the addition of the brother as a defendant, the Arbitration Administrator agreed that he should not be joined, and Dr. Gillette appealed to the Commonwealth Court.

The Court noted that the section of the Act describing the procedure for filing claims states that "a patient or his representative, having a claim for loss or damages from the furnishing of medical services which were or which should have been provided shall file with the Administrator a complaint. . . ."[2] The Act also provides that additional parties who are not health care providers may be joined:

> At any time up to the selection of the panel members, a party may join any additional party who may be necessary and proper to a just determination of the claim. The arbitration panel shall have jurisdiction over such additional parties whether they be health care providers or non-health care providers.[3]

Dr. Gillette's argument was that since the person throwing the snowball was necessary to a just determination of the claim and since the Act provides that "any additional party" may be joined, it was appropriate to join the brother. The counter argument was that the purpose of Act 111 was to provide a method of adjudication of claims of medical malpractice and not for claims based on other tortious conduct. The Commonwealth Court concluded that the Legislature never intended the arbitration panels to deal with questions other than medical malpractice. It stated that:

> The only issue before the panel is that of the alleged failure by the defendants to properly treat an existing injury. The question of how the injury was caused may, and probably would, be germane to that issue, and the person who allegedly caused the injury would properly be called to testify; but the question of that person's liability is irrelevant.[4]

Thus, the Commonwealth Court initially establishes that the purpose of Act 111 is to be narrowly construed to deal with medical malpractice claims and is not to be extended to include other types of personal injury liability.

Mr. Speaker is a partner in the firm of Pepper, Hamilton & Scheetz, which serves as the Society's legal counsel.

[1] *Health Care Services Malpractice Act, 40 P.S. §§ 1301.101* et seq.
[2] *40 P.S. § 1301.401.*
[3] *40 P.S. § 1301.502.*
[4] Gillette, M.D. v. Redinger, et al., *383 Ap.2d 1295, 1298 (Commw. Ct. 1978)*

Course in Abdominal Laparoscopy

October 25, 1978 **Philadelphia**

The Delaware Valley Society for Gastrointestinal Endoscopy will sponsor a Category 1, 4½ credit-hour course "Abdominal Laparoscopy in Diagnosis and Management of Abdominal Disease" on Wednesday afternoon, October 25, 1978, at the Philadelphia County Medical Society, 2100 Spring Garden Street, Philadelphia, PA.

The course, under the direction of Barbara Balis Frank, M.D., will be conducted by a distinguished faculty of speakers and panelists from prestigious medical centers in Pennsylvania, New York, Maryland and Washington, D.C.

The course will focus on the value of laparoscopy in clinical diagnosis; instrumentation and techniques; indications, contraindications and complications; laparoscopic pathologic findings and their interpretation.

For further information, contact Barbara B. Frank, M.D., Crozer-Chester Medical Center, 15th and Upland Avenue, Upland, Chester, PA 19013.

Resident physicians section

'More effective profession' goal of young M.D.s

Brenda Baumann, M.D.
Patrick Jonas, M.D.

Today's physician must be a teacher—of himself, his patients, and his colleagues. The AMA's Resident Physicians Section established a work group on teaching skills of resident physicians to "determine the appropriate approaches to improving teaching skills of residents." Its findings were presented at the AMA-RPS meeting in St. Louis in June. Residents from Hershey, Stanford University Hospital in California, Riverside Methodist Hospital in Ohio, and Maricopa County General Hospital in Arizona were in the work group.

Their presentation in St. Louis emphasized that development of teaching skills should be required of every resident physician. If the present trend of continuing medical education (CME) continues, virtually all physicians will have to participate at some time in the development and design of CME courses.

The presentation placed emphasis on acquiring good interpersonal skills, which are seen as the "basic science" of being a good teacher, a good physician, a good parent, a good spouse, a good learner. The work group identified a program for training physicians in those inter-personal skills necessary to facilitate learning.

The group is now writing an article for resident physicians entitled "How to Approach Your Role as a Teacher." The article will be directed at resident physicians who are given responsibility for providing quality teaching to medical students and junior residents.

The group also is developing an ideal "teaching skills resource center" bibliography which lists books, audio and visual tapes, slides, and articles about teaching.



Pennsylvania delegates to the AMA Resident Physicians Section joined their peers from throughout the country at the AMA meeting in St. Louis in June. Shown above are (l. to r.): A. Patrick Jonas, M.D., Alan Sooho, M.D., Jerris Hedges, M.D., and Diehl Snyder, M.D. Also attending were Robert Snyder, M.D., and J. Pat Tokarz, M.D., 1977-78 chairman of the AMA-RPS.

The residents suggested to the AMA that continuing education courses on teaching skills development in physicians be offered. Specific topics include: how to plan and prepare a conference; the learning process; communications skills for the practicing physician; how to prepare patient education materials; how to pick and get the most out of CME courses; optimal use of self-evaluation courses; resource file organization; speed reading; how to approach your role as a teacher of your patients and colleagues; and the role of the consultant as an educator of the referring physician.

Most of the plans and suggestions put forth stress the physician's role as a teacher of his colleagues and his patients. More important, however, is the physician's ability to continue teaching himself. Graduate medical education must stress "facilitative learning," a new phrase for participating in self education and in the education of others. The RPS work group hopes that resident and practicing physicians can be influenced to be better able to facilitate their own learning, as well as that of their patients and colleagues.

Dr. Baumann, a resident in the department of family medicine at Harrisburg Hospital, is a member of the Governing Council of the PMS-RPS. Dr. Jonas, a family practice resident at Milton S. Hershey Medical Center, is chairman of the PMS Resident Physicians Section, and participated in preparing the program on the physician as teacher.

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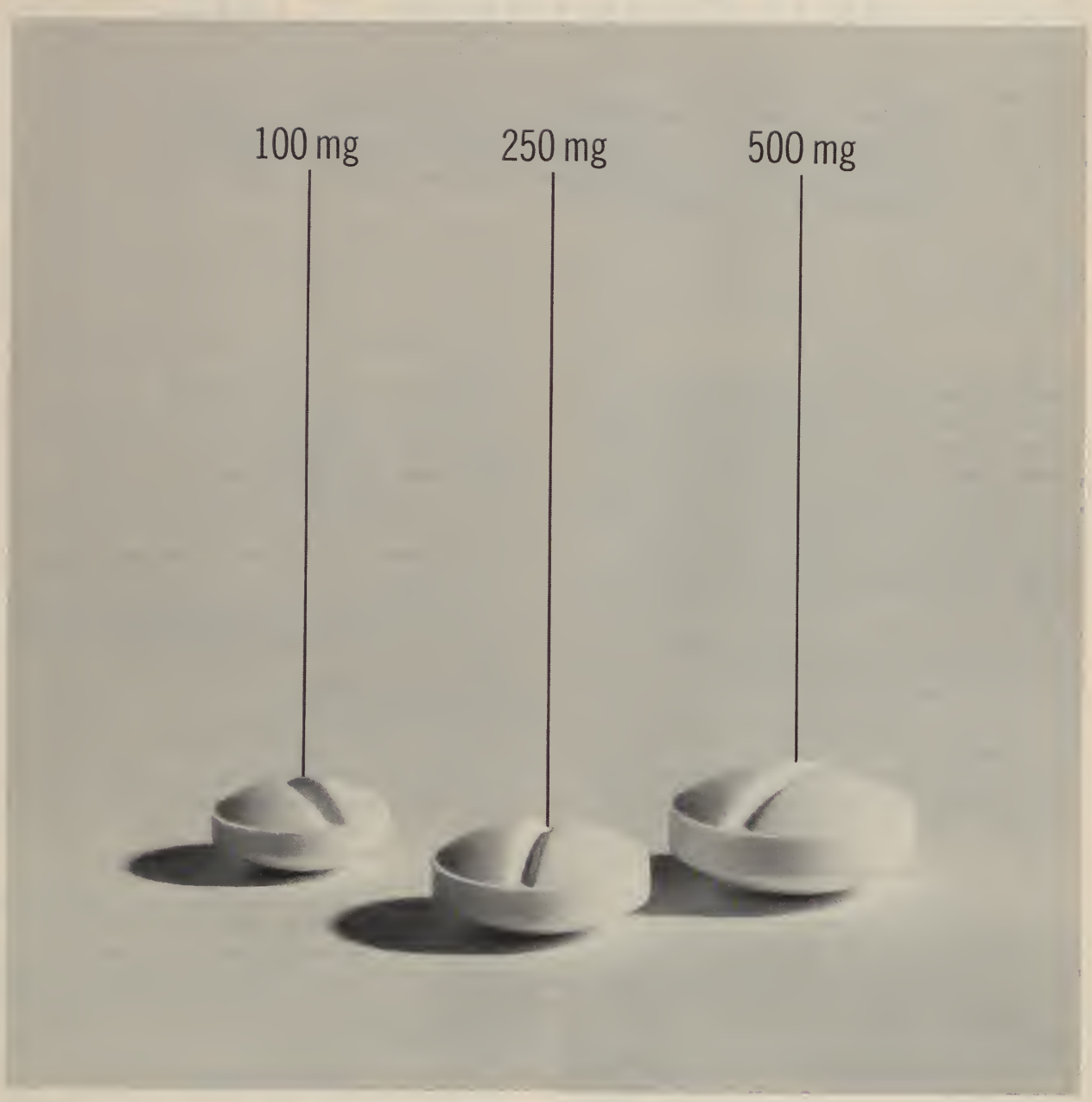
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Health care in Pennsylvania — 1978

This is the Pennsylvania Medical Society's position regarding the health care needs of the Commonwealth's citizens in this election year. It was adopted by the Society's Board of Trustees in June 1978.

Overview

Pennsylvania's gubernatorial election provides a timely occasion on which to reassess the major health care needs of citizens of the Commonwealth and to offer concrete recommendations to both political parties. The Pennsylvania Medical Society, the state's largest doctor organization representing nearly 15,000 physicians, urges the next state administration to give priority to the following health needs of the people of the Commonwealth:

1. Develop a strong Health Department under an able medical leader.
2. Develop and implement creative programs to publicize and improve physician distribution by specialty.
3. Adequately fund medical education.
4. Give necessary administrative support to the State Board of Medical Education and Licensure.
5. Totally revamp the medical assistance program so that it becomes an investment in improving the health of disadvantaged Pennsylvanians rather than a deepening financial burden.
6. Eradicate drug abuse in the MA program.
7. Provide proper professional medical leadership for the state's mental health programs.
8. Provide equal opportunity for doctors to form HMOs.
9. Work for improvements in the state's malpractice reform law.
10. Enact legislation to protect the confidentiality of patients' medical records.
11. Join with the private sector in containing health care costs.
12. Protect physicians who report suspected incidents of child abuse.
13. Crack-down on drug abuse.
14. Prevent industrial waste dumping.
15. Compensate workers afflicted by asbestosis.
16. Implement the Nursing Home Ombudsman Project, including its recommendations on boarding homes.

Strong Department of Health

Fundamental to the health of citizens of the Commonwealth is the establishment and maintenance of an effective Department of Health. Since 1948 the Pennsylvania Medical Society has advocated a stronger Department of Health.

All health services operated by the Commonwealth (including state general hospitals, mental health/mental retardation programs, and medical assistance programs) should be returned to the jurisdiction of the Department and should be adequately staffed by health professionals. The office of the Secretary of Health should not be a political plum. It is a vital link in supporting the health and welfare of people of the Commonwealth. The Secretary, a medical doctor skilled in administration, should not only implement health programs but also provide a bridge to health professionals in the state. The Secretary should be the Governor's advisor on health matters.

The Secretary of Health should be given broad responsibility to coordinate all health-related activities within state government. The Pennsylvania Medical Society urges that the Department of Health be given the funding and the Office of the Secretary be given the authority to support the health of the Commonwealth's citizens.

Several responsibilities of the Department of Health require improvement. Among these is the implementation of an effective statewide communicable disease reporting system that can provide the Secretary of Health with real-time data on the development of epidemics and other hazardous health conditions.

Physician manpower

A shortage of identified primary care doctors persists in Pennsylvania, according to the Pennsylvania Medical Society's latest study on physician manpower (1978). The new PMS report is based on statistics gathered by a state Health Department survey attached to the 1977 license renewals of medical doctors.

Although Pennsylvania's ratio of doctors to population remains high, in the top third of the states, distribution of physicians by specialty and geographic location remains unbalanced. Pennsylvania has more family practice residency training programs (29) than any other state, but it appears that new doctors are not staying in the state. Many rural areas are still short of primary care physicians. Incentives are needed to keep these physicians in Pennsylvania. The Society makes these proposals:

1. The Society recommends encouragement of decen-

tralized quality medical education at undergraduate and graduate levels.

2. Programs for primary care physicians should be encouraged and included in core curricula of Pennsylvania medical schools. Primary care residency programs should be encouraged throughout the Commonwealth.

3. Improved statistical reporting can help predict which counties are in jeopardy regarding physician availability. Early local planning is recommended to meet possible physician shortages.

4. Medical school admissions committees should give special consideration to Pennsylvania residents who are prospective family physicians and especially to those from rural areas. Tuition should be higher for out-of-state students.

5. All Pennsylvania medical schools should have family practice departments to recognize organizationally the importance of family practice curricula.

6. Efforts should be made to expose medical school students to community medicine in their undergraduate years. Elective community medicine courses in selected community hospitals should be encouraged.

7. The proportion of graduate medical education slots available to train family practice residents should be increased. Medical schools should affiliate with appropriate community hospitals to continue the redistribution of residencies in the state. Community hospitals should seek educational affiliation with medical schools.

8. The legislature should provide short term demonstration money to start family practice residencies in need areas and to promote Pennsylvania as a good place to live and practice.

9. Rural physicians and medical schools should provide more experience for resident physicians by allowing them to fill in for physicians on temporary leave.

10. Medical schools should increase enrollment in all years and provide places for transferring American born foreign medical students.

Financing

The Pennsylvania Medical Society recognizes that medical degrees are the most costly of graduate degrees. In recent years the cost of a medical education has mirrored the rise in medical costs. This fall at Hahnemann Medical College, for example, the tuition for freshman medical students will be $10,000, an increase of 64 percent in one year.

The Pennsylvania Medical Society is trying to help. Since 1950 its Educational and Scientific Trust has provided more than $2.5 million to some 1,200 medical students. But the problem is too big for private funding alone.

The PMS believes the most equitable approach to financing Pennsylvania medical students is through a public direct low-interest loan program large enough to cover at least tuition. The program should require a service commitment in Pennsylvania's physician shortage areas and provide a severe financial penalty if the obligation is not fulfilled. The Pennsylvania Higher Education Assistance Agency could administer the program. The Society favors additional direct state support of educational opportunities to those Pennsylvania medical schools responsive to the Commonwealth's physician manpower needs.

State Board of Medical Education and Licensure

"Broken promises" summarizes the history of the State Board of Medical Education and Licensure. In the past the Board has been a mere shell which has promised consumer protection but failed to deliver because of inadequate funding, staff, and supervision. Today there is hope that the State Board of Medical Education and Licensure will perform effectively. This is true mainly because of the following actions taken by the Pennsylvania Medical Society on behalf of citizens of the Commonwealth:

1. Twice in the past 15 years PMS has persuaded the General Assembly to update the Medical Practice Act.

2. In the most recent revision of the Medical Practice Act (1974), the Society engineered tough disciplinary language.

3. The Society secured passage of the Peer Review Protection Act, which provides legal protection to hospital medical staffs and other physician committees which review the work of doctors.

4. The State Society had included in Act 111, the state's Malpractice Reform Act, language which returns to the State Medical Board the money it raises from licensing doctors. This act also calls for the hiring of enough investigators, hearing officers, staff, and attorneys to implement the disciplinary provisions of the Medical Practice Act.

5. After 24 months of stalling by the current administration, the Pennsylvania Medical Society sued the state on January 11, 1978 to force it to carry out the provisions of the law. The State Medical Board has the legal authority to oversee and approve medical education in Pennsylvania. Only the state has the legal authority to restrict and/or revoke a doctor's right to practice medicine. When the state abdicates its responsibility, both the profession and the public are hurt. The Pennsylvania Medical Society urges that all health-related boards be given the funds and personnel necessary to carry out the laws and to protect the public from incompetent and unlicensed practitioners. The Society also urges that bureaucratic obstructions be removed in order that the Board and its professional staff may carry out their work.

Related to incompetency is the physician who is disabled by alcoholism, drug addiction, mental illness, or other physical or mental conditions. The Pennsylvania Medical Society has developed an impaired physician program through which the disabled physician may seek and receive therapy. The goal is rehabilitation. The state should recognize and support the Society's program to rehabilitate impaired physicians.

Physicians' assistants

Specially trained personnel can, with proper supervision, help a physician give comprehensive medical care and, in some cases, increase the number of patients served. While the efficacy of physicians' assistants still is being tested, the Pennsylvania Medical Society believes the way should be cleared for physicians to explore the use of various kinds of assisting personnel.

For this reason the Pennsylvania Medical Society urged passage of Act 79 of 1978, which gives the State Board of Medical Education and Licensure legal authority to regulate physicians' assistants. The Society does not advocate

licensing of physicians' assistants, but supports the recognition and supervision of PAs through rules and regulations approved by the State Medical Board.

Continuing education

The Pennsylvania Medical Society is a leader in continuing medical education. By amending its Bylaws in 1971, PMS became the second state medical society in the country to require of its members evidence of continuing education. With the publication in 1977 of the Pennsylvania Insurance Department's risk management requirements, the Society's privately sponsored continuing education program became part of state law. The Insurance Department's risk program requires that insureds qualify for the continuing education program of the Pennsylvania Medical Society or its equivalent.

Continuing education is the most readily available instrument to demonstrate a commitment to maintaining competency. The Society, however, is investigating other techniques and pledges to maintain leadership in the quest to retain competence and skills.

Medical assistance program

Because the legislature has viewed the welfare program as an expense rather than an investment, it continues to absorb vast amounts of money with no measurable improvement for its clients. Funded at the lowest possible levels, particularly in the area of medical assistance, the welfare program succeeds only in perpetuating itself at increasing cost. While living conditions and nutrition probably have more long-term impact on health than any service a doctor or hospital can provide, the program lurches along with allotments at the subsistence level.

In the medical assistance portion of the welfare program, too, the state remains penny wise and pound foolish. It pours more and more money into hospital care, the most expensive type of medical care, while actually reducing the amount it pays doctors. It's little wonder that physicians are reluctant to participate in the MA program.

Drug abuse in the MA program

The Department of Public Welfare has been unable to police the MA drug program. The Pennsylvania Medical Society, through its Medical Care Foundation, has operated a Professional Drug Utilization and Quality Appraisal Program under contract with Capital Blue Cross. Since July 1977 Capital Blue Cross has forwarded the names of hundreds of MA recipients who appear to be abusing the MA drug program. Available information tends to indicate that DPW has taken little or no corrective action.

Certainly fraud and abuse are not limited to MA recipients. The Society has consistently urged the Department of Public Welfare to prosecute known cases of physician fraud and/or abuse and to report them to the State Board of Medical Education and Licensure.

At the same time, the Society has cautioned against guilt by innuendo. The mere fact that medicaid pays a significant amount to a particular physician does not necessarily mean the physician is abusing the program.

Pennsylvania's medical assistance program is a failure. Many doctors do not participate in the program because of its cumbersome administration and grossly inadequate reimbursement levels. Clinic reimbursement exceeds office visit reimbursement. At $6.00 per visit, office overhead quickly overrides medical assistance income.

Fees notwithstanding, the program is a failure because of its disincentives to participation:

1. Only 82 procedures have been reimbursed on an outpatient basis (clearly an encouragement for patients to demand hospital admission);
2. Physicians must complete a separate invoice for each patient even when several members of a family are treated at the same time;
3. Forms are invasive and burdensome;
4. Invoices must be typed to insure more prompt payment;
5. Medicare/medicaid cross-over claims are difficult and time-consuming;
6. Payment vouchers do not identify the patient involved;
7. Physicians continue to be referred to as "vendors";
8. Some college students appear to be abusing the program.

MA program reform: PMS recommendations

The goals of the next administration should be to:

1. Place the medical assistance program in the Health Department. Limit Department of Public Welfare's responsibility to eligibility determination, enrollment, registration, and those functions that require a welfare orientation.
2. Make Blue Shield the fiscal intermediary for the Pennsylvania program. Medicaid recipients should be given Blue Cross/Blue Shield cards so they may truly be equal with other citizens in the medical marketplace. Blue Shield serves two-thirds of the state's residents, more than 8 million persons, and possesses a massive technical and computer capability. It currently processes nearly 11 million claims a year, including the in-hospital portion of medicaid.
3. Improve MA administration by adopting rational regulations which recognize both the needs and demands of medical assistance recipients and the professional and business aspects of medical practice;
4. Establish reasonable levels of reimbursement for physicians' services so that medical assistance recipients have the same opportunity as other citizens to receive the services of a private practitioner.
5. Provide for a viable plan for financing the costs of the MA program consistent with the Commonwealth's commitment to provide disadvantaged citizens with an equal opportunity to seek and receive quality medical care available to the general population;
6. Establish professionally developed cost and quality controls to assure that services are provided in the most efficient manner and least expensive setting, consistent with quality medical care;
7. Increase number of out-patient procedures covered by medical assistance to help reduce the number of hospital admissions;

8. Redefine medical assistance eligibility to eliminate abuses;

9. At a minimum, the administration should fund pilot projects in alternate methods of financing and delivery of medical assistance. It should test patient response to adequate physician reimbursement, particularly in the office setting.

Because the welfare problem will be with us for a long time, we should view it as an opportunity to improve lives rather than as an ever increasing burden.

Hospital costs

The rising cost of hospital care is a national problem. The Pennsylvania Medical Society endorses the American Medical Association and the American Hospital Association in their quest for a voluntary cost containment program. PMS has joined the Hospital Association of Pennsylvania in the formation of a statewide committee to implement the voluntary cost containment program. The Committee seeks to reduce hospital costs two percent per year for two years.

Hospitals are already one of the most regulated industries in the country. Thus far, no one has been able to design legislation which deals equitably with the cost problem in every type of hospital. The voluntary effort places maximum responsibility for lowering costs at the local level.

The Pennsylvania Medical Society again urges state government to get out of the general short-term hospital business. The state-owned general hospitals should be turned back to the communities. As a business manager the state has not done a good job. Costs are higher than in the private sector and the institutions are not responsive to the quality and occupancy pressures of the private marketplace.

Health planning

Duplication of underutilized medical facilities imposes an unacceptable burden on the economic resources of the Commonwealth. Thus, the Society supports hospital certificate of need legislation and uniform standards for financial reporting of hospitals. Health planning legislation, rules, and regulations must allow for local medical input to guard against reduction in the quality of care.

Mental health

The Society is deeply concerned about the administration and program development of the office of mental health within the Department of Public Welfare. More than one million Pennsylvanians affected by the state's mental health programs are not receiving proper attention. The program lacks adequate professional medical input and is oriented to cost rather than to quality of care.

The Society urges passage of amendments to the current Mental Health Procedures Act which make available treatment for persons in whom the need is great and in whom it is likely that lack of treatment would result in serious consequences. Current procedures require attempts of harm to self or others before even involuntary care can be secured.

Many state mental health programs do not have or do not encourage adequate medical supervision. To assure quality care, the Society urges that all psychiatric aspects of mental health programs be under physician supervision.

Emergency medical services

Today Pennsylvania is on the way to having a well-planned, coordinated statewide emergency medical system. The foundation for this system was the white paper on emergency medical care published by the Pennsylvania Medical Society in 1971. The paper later was adopted by Governor Shapp and his administration and became the foundation for the development of the current emergency medical system in Pennsylvania. While most of its recommendations have been implemented, a few still await action. Senate Bill 339, for example, would provide minimum standards for all state ambulance services. It has passed the Senate and is in House Committee.

Health Maintenance Organizations

We believe the primary objective of state government and of the Pennsylvania Medical Society should be to support quality medical care to all Pennsylvanians at a reasonable cost. To achieve this, all forms of physician service should be allowed to compete freely.

Legislation now exists favoring the creation and operation of health maintenance organizations (HMOs) organized and directed by non-physicians with government subsidy.

Legislation which permits the organization and operation of physician majority HMOs also is needed in Pennsylvania. Only when all parties have an equal opportunity to compete in the marketplace to provide medical service will the citizens of the Commonwealth be best served.

Malpractice

The malpractice problem, while no longer front page news, continues to be serious. What began in late 1974 as a crisis for the medical profession has now become a serious threat to the legal and other professions, and to corporations in the area of product liability.

With the passage in late 1975 of Act 111, the state's new malpractice reform act, a base was established for managing the medical malpractice problem in Pennsylvania. While cases testing the constitutionality of various portions of Act 111 continue, the Office of Medical Malpractice Arbitration gathers accurate statistics on the incidence of malpractice claims in Pennsylvania.

Unfortunately the "reform" portions of Act 111 are mostly cosmetic. To address the fundamental problems of the malpractice insurance crisis, the Society urges the passage of the following amendments to Act 111:

1. Permit Pennsylvania professional corporations to be covered under the Catastrophe Loss Fund;

2. Enact a two-year statute of limitations with only one additional year for late discovery;

3. Limit payment for pain and suffering to "grievous impairment;"

4. Send "punitive damages" to the State Board of Medical Education and Licensure;

5. Provide the option to elect binding arbitration without appeal to the court;
6. Eliminate PSRO norms, standards, and criteria;
7. Allow "periodic payments" of malpractice awards.

Health fraud

It is ironic in this age of so-called "miracle" medicine that merchants of fraud and chicanery still flourish. Every few weeks another easy method to maintain or restore health appears. The method may be rooted in acupuncture or laetrile or megavitamins or B-17; the list is endless.

The protocol for scientific validity requires duplicate findings in many laboratories. This established system should not be bypassed by the legislature.

Confidentiality

One of the cornerstones of medical treatment is the bond of confidentiality which exists between physician and patient. Recently the intrusion of third-party payers into the physician/patient relationship has threatened to shatter that bond and expose confidential medical information. This threat has become imminent with the advent of the computer.

The Pennsylvania Medical Society is preparing a bill on confidentiality of health care information. The Society views this as a serious matter which requires immediate attention.

Medical costs: PMS action

The Pennsylvania Medical Society, deeply concerned about the rising cost of medical care, has taken the following actions:

1. It has joined the national voluntary effort to contain hospital costs.

2. It is cosponsoring with the Hospital Association of Pennsylvania and the Pennsylvania Osteopathic Medical Association an intensive two-day seminar to bring together leaders of business, industry, labor, and the professions to develop cost-saving strategies acceptable to all.

3. As early as 1976 it supported home hemodialysis, noting that institutional dialysis can be three times as expensive. President Carter signed into law in 1978 a provision permitting reimbursement for home hemodialysis. The Society reiterates its call to the Secretary of Health and other state officials to revise their reimbursement policies to encourage home dialysis.

4. In September 1977 the Society urged its members to use home health care as another way to reduce costs. A widely reprinted Society white paper on home health care has helped raise physician awareness of the advantages and feasibility of home health care. Studies have shown that when home health care services are available, costs are competitive with nursing homes and can help relieve the shortage of nursing home beds.

5. In May 1978 the Society published a major scientific paper entitled "A Comprehensive Plan for Spinal Cord Injury Services in Pennsylvania—Report of a Special Committee." The paper, prepared under auspices of the Pennsylvania Department of Health, brought together for the first time in Pennsylvania comprehensive data on spinal cord injury. It is hoped the paper will generate increased emphasis on treatment and rehabilitation of spinal cord injury patients. Secretary of Health Leonard Bachman, M.D., in a forward to the paper said, "Spinal cord damage resulting in paralysis constitutes one of the most devastating illnesses known to man. . . . The astronomical monies involved in maintaining helpless victims must be transferred to providing the care that will return them to fulfilling and productive lives . . ."

6. The Society has sponsored more than 50 practice management seminars during the past decade to train physicians in managing their offices more efficiently. According to one calculation, if all physicians improved their efficiency 4 percent it would be like adding another graduating class of physicians.

7. The Society cooperates fully with the Department of Health in the implementation of the generic drug law. The Society uses its communications network to alert physicians to the requirements of the generic prescribing law and keep them informed of changes in the state formulary.

8. The Society's cost containment activities actually predate the national effort. The Board of Trustees authorized publication of a white paper on health care costs in the August 1977 issue of PENNSYLVANIA MEDICINE. The paper listed specific areas in which physicians, hospitals, and the Medical Society could begin cost-saving activities.

9. More and more we are recognizing that many of today's illnesses are related to lifestyle. For this reason the Society has increased its emphasis on health education. In addition to its weekly radio programs and health columns, the Society has supported educational ventures such as Tel-Med, a telephone health education program endorsed by local county medical societies. The Society's health exhibit, keyed to physical fitness, has been used extensively by county societies and auxiliaries at health fairs promoting preventive medicine.

Medical cost reduction recommendations

Although eliminating unneeded hospital admissions through out-patient surgery is commendable, as is the shortening of hospital stays, the prevention of illness would be even more economical. To this end we urge *consideration of the total health environment*. Pursuing preventive health in our total environment requires action in many areas. We recommend:

1. Greater emphasis on adult physical conditioning through lifetime sports.

2. More investments by the Commonwealth and local communities in neighborhood and school recreational facilities, particularly close to high density population centers.

3. Increased attention to effective school nutritional and fitness programs.

4. Maintaining the drinking age in Pennsylvania at 21.

5. Requiring helmets for motorcyclists. This recommendation is made on the basis of statistics of the injury rate to persons without protective headgear involved in motorcycle accidents.

6. Continuation of the hypertension screening program of the Department of Health and the American Heart Association, Pennsylvania Affiliate.

7. Programs designed to improve the living conditions of the indigent. Such programs might be the most effective way to reduce medical assistance costs (See section on medical assistance).

8. Using cigarette tax monies for recognized research as long as implementation of this recommendation does not create a new bureaucracy.

9. Reducing health costs by effective preventive health measures to reduce pollution, discover and treat high blood pressure, immunize youngsters, reduce obesity, and curtail smoking and excessive drinking.

The Society advocates consolidation of hospital inspections. Hospitals are already one of the most regulated industries in the nation. Consolidation would produce significant cost savings. To that end we support HB-1783 which calls for elimination of duplicate inspection of hospitals by state government.

The Society supports the AMA's universal claim form because it could cut paper processing costs in government programs such as medicaid and medicare. An example of the government paper blizzard is the form prepared by the Medical Assistance Management Information System of the Department of Public Welfare. DPW's intent is laudable but the form serves only to increase paperwork and is not cost effective.

Uniform anatomical gift

We are pleased that our initiative in seeking passage of the uniform anatomical gift act has culminated, with Society assistance, in the distribution of the anatomical donor card with driver's license renewal applications.

The Society urges that sufficient state funds be provided to the Humanities Gift Registry so that it can be adequately staffed and so that an effective means of coordinating, collecting, and transporting donor material to needed facilities can be established.

Child abuse

The Society enthusiastically supported passage of the Child Protective Services Act 124 of 1975. The law extends immunity from guilt to physicians, who are required to report suspected cases of child abuse. Subsequently, however, some physicians have been sued for complying with the law. The Society urges relief for physicians who comply with the reporting requirements of the law. We believe the Commonwealth should defend these physicians if they are sued for making mandated reports.

Drug abuse

The Society continues to be concerned about drug abuse in Pennsylvania. Because some drugs enter the illicit market through the misguided activity of a handful of physicians, the Society has pledged to cooperate in the crackdown on physician offenders. We cooperate by recommending expert witnesses to testify for law enforcement officials in those cases in which responsible charges are brought against a physician for illegally prescribing or dispensing drugs. The Society also is cooperating with drug enforcement officials in making available to county medical societies and hospital medical staffs programs to train doctors in drug abuse prevention.

Occupational health and the environment

While Pennsylvania's Department of Environmental Resources has provided leadership in the fight against pollution, there are legal loopholes which need further attention. Illegal dumping of industrial chemical wastes is an increasing threat. In Pennsylvania, chemical product companies apparently are not required to report their disposal plans and procedures with any specificity, nor are waste haulers required to register. The Delaware and Schuylkill rivers already have been sites of industrial waste incidents. We urge action to stop industrial waste dumping.

Belatedly government has recognized the serious long-term health threat caused by asbestos dust. Workers exposed to asbestos are at greater risk of contracting asbestos-related diseases, including cancers of the lung, stomach, colon, and rectum. In 1972 the legislature amended Pennsylvania's Workmen's Compensation Act to include asbestosis and related diseases. To collect maximum benefits, however, the worker must prove exposure to asbestos after 1973, an almost impossible feat because most contractors ceased using it in 1972. Senate Bill 1022 recognizes the lead time of as much as 25 years in developing and diagnosing the disease and would provide full benefits to Pennsylvania workers who have contracted asbestos-related diseases on the job. We believe Pennsylvania workers who can document their prolonged exposure to asbestos should receive fair compensation.

Nursing and boarding homes

As the average life span of Pennsylvanians has grown, so have the problems of the elderly. With the fragmentation of the family, an increasing number of the elderly are being placed in nursing homes. Conditions in nursing homes range from excellent to deplorable.

In 1976 the Pennsylvania Medical Society endorsed the findings and recommendations of the Nursing Home Ombudsman Project and urged the Governor to implement them. Subsequently the project was caught in the budget squeeze and was not funded in 1978.

While the current Secretary of Health is to be commended for his emphasis on nursing homes and their licensing, additional work still must be done. The Society urges that the Ombudsman Project be properly funded and staffed and that its recommendations be carried out.

Equally shocking are the scandalous conditions that exist in some personal-care boarding homes. As early as 1971 the Pennsylvania Medical Society called for executive and legislative action, including licensing and inspection, to improve quality in substandard public boarding homes. Two bills (HB-500 and SB-456) which address this issue are now before the legislature. We urge action by state government to assure that the elderly and mental patients in boarding homes funded by tax monies are not exploited.

National health insurance

National health insurance per se is not a state issue, but

it is important that the Pennsylvania Medical Society's position be known. PMS supports HB-1818, the Comprehensive Health Care Insurance Act of 1977.

This national health insurance bill, or any bill which PMS would support, should contain the following principles:

1. All citizens should have equal access to quality medical care through a uniform and comprehensive health insurance plan.
2. It must provide protection against the cost of catastrophic illness without limit.
3. It should rely on the private insurance sector to the greatest extent possible to tap existing capacity and expertise.
4. The federal government should be responsible for establishing minimum national standards for eligibility determination, premium structure, program administration, benefit coverage, and other basic policy provisions.
5. All citizens must have the option of selecting physicians and hospitals of their choice.
6. Federal financing should be limited to paying premiums for the aged, medically indigent, and unemployed.
7. Cost sharing by insureds should be included.

National health insurance is not a cure-all but it can assure that everyone, regardless of income, has access to quality medical care through a uniform and comprehensive insurance plan and to guaranteed protection against catastrophic medical costs.

Summary

The Pennsylvania Medical Society believes the next state administration should give priority to the following health needs in the Commonwealth:

1. Develop a strong Health Department under an able medical leader.
2. Develop and implement creative programs to publicize and improve physician distribution by specialty.
3. Adequately fund medical education.
4. Give necessary administrative support to the State Board of Medical Education and Licensure.
5. Totally revamp the medical assistance program so that it becomes an investment in improving the health of disadvantaged Pennsylvanians rather than a deepening financial burden.
6. Correct drug abuse in the medicaid program.
7. Provide proper professional medical leadership for the state's mental health programs.
8. Provide equal opportunity for physicians to form HMOs.
9. Work for improvements in the state's malpractice reform law.
10. Enact legislation to protect the confidentiality of patients' medical records.
11. Join with the private sector in containing health care costs.
12. Protect physicians who report suspected incidents of child abuse.
13. Crack down on drug abuse.
14. Prevent industrial waste dumping.
15. Compensate workers afflicted by asbestosis.
16. Implement the Nursing Home Ombudsman Project, including its recommendations on boarding homes.

Continuing Education Programs 1978-1979

Institute for Medical Education and Research
Geisinger Medical Center

Management of Rheumatic Diseases - Update
Wednesday, September 20, 1978
9 a.m. to 5 p.m. Tuition: $40

Common Problems in Neurology
Wednesday, October 4, 1978
9 a.m. to 5 p.m. Tuition: $40

4th Annual Emergency Medicine Seminar
Wednesday, October 18, 1978
9 a.m. to 5 p.m. Tuition $40

Clinical Update in Gynecology
Wednesday, October 25, 1978
9 a.m. to 5 p.m. Tuition $40

Ophthalmology Update for Family Physicians
Wednesday, November 1, 1978
1 p.m. to 5 p.m. Tuition: $25

Clinical Advances in Pediatrics
Wednesday, November 15, 1978
1 p.m. to 5 p.m. Tuition: $25

Advances in Clinical Practice - 1979*
Saturday, Sunday, February 10, 11, 1979
9 a.m. to 5 p.m. Tuition $105

Office Treatment for Common Problems in Otolaryngology
Wednesday March 7, 1979
9 a.m. to 5 p.m. Tuition: $40

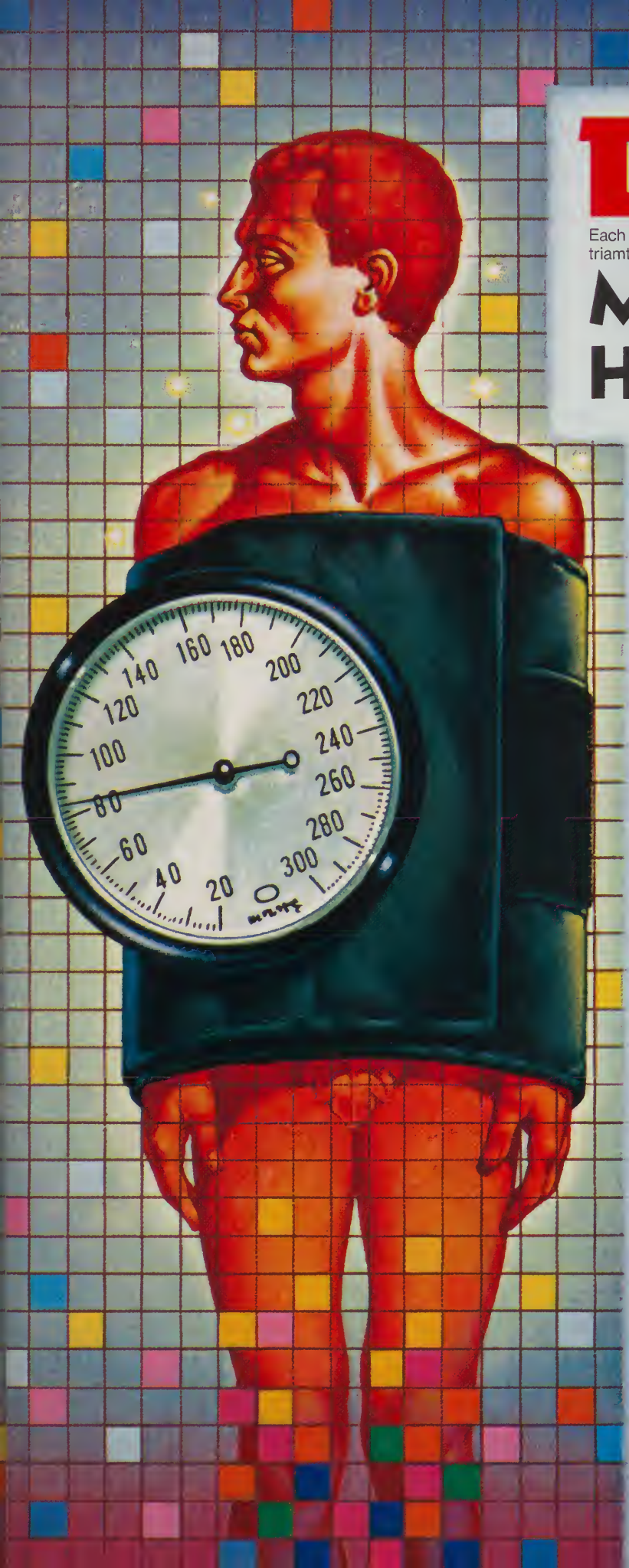
Endocrine Disorders of Pituitary, Pancreas & Parathyroid
Wednesday, March 21, 1979
9 a.m. to 5 p.m. Tuition: $40

Current Topics in Surgery
Wednesday, April 4, 1979
9 a.m. to 5 p.m. Tuition: $40

Advances in Dermatology for the Practitioner
Wednesday, April 18, 1979
1 p.m. to 5 p.m. Tuition: $25

As an organization accredited for continuing medical education, the Geisinger Medical Center certifies that these activities meet the criteria for credit hours in Category I of the Physician's Recognition Award of the American Medical Association. (Refer to each program — full day - 7 hours credit and ½ day - 4 hours credit).

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* **Warning**
This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

Contraindications: Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K+ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K+ frequently; both can cause K+ retention and elevated serum K+. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

Supplied: Bottles of 100 and 1000 capsules; Single Unit Packages of 100 (intended for institutional use only).

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And, in anxiety/depression, Adapin® (doxepin HCl) often helps restore disturbed sleep patterns, such as early morning awakening, with a single daily dose at bedtime![1] Adapin quickly relieves the patient's anxiety, gradually brightens his mood and outlook, with optimal antidepressant response usually evident within two to three weeks.

1. Goldberg HL, Finnerty RJ, Cole JO: Doxepin: Is a single daily dose enough? *Am J Psychiatry* 131:1027-1029, 1974.

Brief Summary of Prescribing Information
ADAPIN® (doxepin HCl) Capsules

Indications—Relief of symptoms of anxiety and depression.

Contraindications—Glaucoma, tendency toward urinary retention, or hypersensitivity to doxepin.

Warnings—Adapin has not been evaluated for safety in pregnancy. No evidence of harm to the animal fetus has been shown in reproductive studies. There are no data concerning secretion in human milk, nor on effect in nursing infants.

Usage in children under 12 years of age is not recommended. MAO inhibitors should be discontinued at least two weeks prior to the cautious initiation of therapy with this drug, as serious side-effects and death have been reported with the concomitant use of certain drugs and MAO inhibitors.

In patients who may use alcohol excessively potentiation may increase the danger inherent in any suicide attempt or overdosage.

Precautions—Drowsiness may occur and patients should be cautioned against driving a motor vehicle or operating hazardous machinery. Since suicide is an inherent risk in depressed patients they should be closely supervised while receiving treatment. Although Adapin has shown effective tranquilizing activity, the possibility of activating or unmasking latent psychotic symptoms should be kept in mind.

Adverse Reactions—Dry mouth, blurred vision and constipation have been reported. Drowsiness has also been observed.

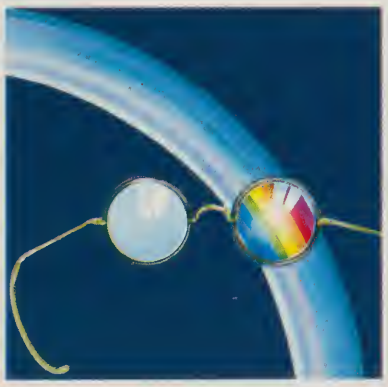
Adverse effects occurring infrequently include extrapyramidal symptoms, gastrointestinal reactions, secretory effects such as sweating, tachycardia and hypotension. Weakness, dizziness, fatigue, weight gain, edema, paresthesias, flushing, chills, tinnitus, photophobia, decreased libido, rash and pruritus may also occur.

Dosage and Administration—In mild to moderate anxiety and/or depression: 25 mg t.i.d. Increase or decrease the dosage according to individual response. Daily dosage, up to 150 mg may be taken at bedtime without loss of effectiveness. Usual optimum daily dosage is 75 mg to 150 mg per day not to exceed 300 mg per day.

Antianxiety effect usually precedes the antidepressant effect by two or three weeks.

How Supplied—Each capsule contains doxepin, as the hydrochloride: 10 mg, 25 mg, 50 mg and 100 mg capsules in bottles of 100 and 1000.

For complete prescribing information please see package insert or PDR.



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New clinical developments in neurologic, obstetric, and neonatal anesthesia; muscle relaxants, neuromuscular transmission; cardiac drugs; special techniques. Includes workshop on cardiac problems. (21 hrs. AMA Cat. I; AANA)

Sept. 22-24 **Adolescent Medicine** Fee: $180

A wide range of carefully selected clinically oriented topics and workshops for physicians with adolescent patients. (18 hrs. AMA Cat. I; AAFP prescribed hours)

Sept. 25-29 **General Diagnostic Radiology** Fee: $320

A broadly based clinical review of neurologic, urologic, chest, cardiac, GI, bone and joint radiology including CAT scanning. (28 hours AMA Cat. I)

Oct. 18-Dec. 20 **Consultations In Internal Medicine** Fee: $350

New departure in clinical problem solving relating exclusively to complex diagnostic problems and therapeutic options in internal medicine. For the experienced internist. (Wednesdays, 4-7 p.m.) (30 hrs. AMA Cat. I; AAFP prescribed hours)

Oct. 19-20 **Sherlockian Dermatopathology** Fee: $225

Application to dermatopathology and pathology of the methods of deductive and analytic logic practiced by the world's most famous consulting detective—Sherlock Holmes. (14 hrs. AMA Cat. I; 12½ AAD pending)

Oct. 21-22 **Robert S. Hotchkiss Symposium—Male Infertility** Fee: $200

An update on the science underlying a rational clinical approach to diagnosis and treatment of male infertility problems. (14 hours AMA Cat. I)

Oct. 28-29 **Office Management Of Common Orthopedic Problems** Fee: $180

For emergency room and primary care physicians. Emphasis on approaches to neck and shoulder pain, low back pain and disc disease, common fractures, the painful knee and sprained ankle. Treatment workshops in splinting, casting, strapping. (14 hours AMA Cat. I; ACEP; AAFP prescribed hours)

Oct. 30-Nov. 1 **Clinical Rheumatology For Primary Physicians** Fee: $240

Intensive clinical course for internists and family physicians. Lectures, case studies and workshop on physical diagnosis. (21 hours AMA Cat. I; AAFP prescribed hours)

Nov. 2-4 **Echocardiography** Fee: $160; $80

Nov. 2, 3—An introduction to fundamentals for better understanding of indications, limitations and interpretation of echocardiograms in the clinical literature and patient records. *Nov. 4*—Intensive practice sessions on interpretation of echocardiograms using the case study method and self assessment evaluations. (21 hours AMA Cat. I; AAFP prescribed hours)

December 2-3 **Practicum In Psychiatry & Criminal Law** Fee: $160

For psychiatrists who may function in the legal arena: tests of competency, insanity as a defense, pre-sentence consultation and the psychiatrist as expert witness. (14 hours AMA Cat. I)

Dec. 7-8 **Diagnosis Of Muscular Diseases** Fee: $160

Intensive practical review of essential methodology and advanced techniques in the diagnosis of neuromuscular diseases for neurologists, neurophysiologists and physiatrists. (14 hours AMA Cat. I)

Dec. 9-10 **Psychiatry For Primary Care Physicians** Fee: $185

Identification and management of crisis and emergency situations in office practice: depression, anxiety attacks, acute psychotic states, hysteria, psychosomatic complaints, suicide threats and drug abuse. Guidelines for using common psychoactive drugs. (14 hours AMA Cat. I; AAFP prescribed hours)

Dec. 11-12 **Clinical Electrodiagnosis Of Neuromuscular Diseases** Fee: $160

Presents advanced and unusual techniques of electromyography and nerve stimulation studies. For clinical neurophysiologists, neurologists, neurosurgeons, orthopedists and physiatrists. (14 hours AMA Cat. I)

Dec. 11-15 **Neurosurgery /New York City 1978** Fee: $385

Combines the resources and faculties of the Departments of Neurosurgery in the seven NYC medical schools. Features state-of-art lectures, clinical presentations, video-tape programs on operative techniques, informal sessions with faculty and a program at the Neurological Institute (Columbia). (34 hours AMA Cat. I; PRA in Neurosurgery)

Jan. 3-May 30, 1979 **Internal Medicine An In-Depth Review** Fee: $485

A sophisticated, current review of internal medicine. Major attention to disease mechanisms and advances in diagnosis and therapeutics with heavy clinical orientation. Helpful for ABIM and AAFP exam review. (Wednesday, 4-7 p.m.) (66 hours AMA Cat. I; AAFP)

Fees and dates subject to change. For information or course brochure, write or phone: Registration Dept., NYU Post-Graduate Medical School, 550 First Avenue, New York, NY 10016; 212-679-8745 (24-hr telephone).

Official Call 1978 Annual Session
Pennsylvania Medical Society House of Delegates

The 1978 Annual Session of the House of Delegates of the Pennsylvania Medical Society will be called to order at the Host Farm Resort Motel, Lancaster, Pennsylvania on Monday, October 30, 1978 at 10:00 a.m. The second session of the House of Delegates is scheduled for Tuesday, October 31, 1978 at 1:00 p.m. The third and concluding session of the House of Delegates will be held Wednesday, November 1, 1978 at 9:30 a.m.

Elections

In accordance with Article X, Section 3 of the Constitution and Chapter IV, Section 2 of the Bylaws and Standing Rule Number 1 of the House of Delegates (revised October 23, 1972) of the Pennsylvania Medical Society, the following nominations and/or elections will be in order at the second session, Tuesday afternoon, October 31, 1978:

General Officers to be elected are a vice president, a secretary, a speaker of the House of Delegates, and a vice speaker of the House of Delegates.

In accordance with Article VIII, Section 3 of the Constitution and Standing Rule Number 1 of the House of Delegates of the Pennsylvania Medical Society, elections will be in order for a trustee and councilor for the Fourth Councilor District to serve five (5) years to succeed George A. Rowland, M.D., Columbia County, who is not eligible for re-election; a trustee and councilor for the Fifth Councilor District to serve for five (5) years to succeed Raymond C. Grandon, M.D., Dauphin County, who is eligible for re-election.

In accordance with Chapter XIV, Section 2 (e) of the Bylaws of the Pennsylvania Medical Society, elections for five (5) delegates and five (5) alternates to the American Medical Association are in order. The term is for two (2) years beginning January 1, 1979. Delegates whose terms expire December 31, 1978 are: R. William Alexander, M.D., Berks County; Raymond C. Grandon, M.D., Dauphin County; William J. Kelly, M.D., Allegheny County; William Y. Rial, M.D., Delaware County; George A. Rowland, M.D., Columbia County.

The Committee to Nominate Delegates and Alternates to the AMA makes the following nominations for delegates for two (2) years commencing January 1, 1979:

1. R. William Alexander, M.D. (Berks County)
2. James B. Donaldson, M.D. (Philadelphia County)
3. Raymond C. Grandon, M.D. (Dauphin County)
4. William J. Kelly, M.D. (Allegheny County)
5. William Y. Rial, M.D. (Delaware County)

Alternate delegates whose terms expire December 31, 1978 are: Donald C. Brown, M.D., Westmoreland County; Betty L. Cottle, M.D., Blair County; James B. Donaldson, M.D., Philadelphia County; Michael P. Levis, M.D., Allegheny County; John L. Kelly, M.D., Delaware County.

The Committee to Nominate Delegates and Alternates to the AMA makes the following nominations for alternate delegates for two (2) two-year terms commencing January 1, 1979:

1. Donald C. Brown, M.D. (Westmoreland County)
2. Betty L. Cottle, M.D. (Blair County)
3. Joseph N. Demko, M.D. (Lackawanna County)
4. John L. Kelly, M.D. (Delaware County)
5. Michael P. Levis, M.D. (Allegheny County)
6. Carol N. Maurer, M.D. (Venango County)
7. Donald E. Parlee, M.D. (Bucks County)
8. Jonathan E. Rhoads, Jr., M.D. (Philadelphia County)

(Note: There exists a strong possibility that by the time of the meeting of the PMS House of Delegates, Pennsylvania will have sufficient AMA members to qualify for an eleventh delegate and alternate delegate. If that situation exists at the time of the House of Delegates, your committee will be prepared to place additional names in nomination.)

It is necessary to elect a delegate to fill the unexpired term of George A. Rowland, M.D. Section 5.101 of the AMA Constitution and Bylaws states that no person, while serving as a voting member of the Board of Trustees, shall be a delegate or an alternate delegate to the AMA House of Delegates. Dr. Rowland was elected to serve on the AMA Board of Trustees at the June 1978 annual meeting. Dr. Rowland's term as a delegate expires December 31, 1978.

The Committee to Nominate Delegates and Alternates to the AMA makes the following nomination for the unexpired term, effective immediately and ending December 31, 1978.

1. James B. Donaldson, M.D. (Philadelphia County)

Also to be elected will be two (2) members to serve on the Committee to Nominate Delegates and Alternates to the American Medical Association. The term of Charles K. Zug, III, M.D., Northampton County expires; he is eligible for re-election. In addition the term of Charles R. Shuman, M.D., Philadelphia County, expires; he is eligible for a second three-year term.

In accordance with Article IX, Section 5 of the Constitution, the Board of Trustees nominates the following members for vacancies on the Judicial Council: for the office now held by Russell B. Roth, M.D., Erie County, the Board nominates Orlo G. McCoy, M.D., Bradford County; Sydney E. Sinclair, M.D., Lycoming County; and James L. Killius, M.D., Somerset County. For the office now held by George E. Farrar, Jr., M.D., Philadelphia County, the Board nominates William J. Kelly, M.D., Allegheny County; Robert P. Dutlinger, M.D., Dauphin County; and George E. Farrar, Jr., M.D. For the office now held by Cyrus B. Slease, M.D., Armstrong County, the Board nominates Cyrus B. Slease, M.D.; H. Thompson Dale, M.D., Centre County; and Robert S. Sanford, M.D., Tioga County.

Elections will be held for District Censor from each component medical society to serve for one (1) year following the close of the 1978 House of Delegates session, as required by Chapter IV, Section 4 of the Bylaws of the Pennsylvania Medical Society. The component county medical societies submitted the following nominations for District Censor:

Adams, W. North Sterrett; Allegheny, William D. Stewart; Armstrong, Donald Minteer; Beaver, John G. Hallisey; Bedford, ; Berks, Brian A. Wummer; Blair, ; Bradford, Arthur B. King; Bucks, Stanley F. Peters; Butler, Robert C. McCorry; Cambria, Warren F. White; Carbon, ; Centre, H. Thompson Dale; Chester, ; Clarion, Charles C. Huston; Clearfield, Fred Pease; Clinton, ; Columbia, Philip M. Irey, Jr.; Crawford, David D. Kirkpatrick, Jr.; Cumberland, Hans S. Roe; Dauphin, Robert P. Dutlinger; Delaware, Arthur S. Reynolds; Elk-Cameron, ; Erie, Robert L. Loeb; Fayette, Veronica Binns; Franklin, Albert W. Freeman; Greene, Arthur J. Patterson; Huntingdon, ; Indiana, ; Jefferson, Nicholas F. Lorenzo; Lackawanna, Thomas A. O'Boyle; Lancas-

ter, William G. Ridgway; Lawrence, John M. Corbett; Lebanon, ; Lehigh, Robert J. Beitel, Jr.; Luzerne, Robert Kerr; Lycoming, Franklin G. Wade; McKean, Bruno P. Sicher; Mercer, ; Mifflin-Juniata, ; Monroe, Mark Pliskin; Montgomery, Rudolph K. Glocker; Montour, William O. Curry, Jr.; Northampton, Walter J. Filipek; Northumberland, Nicholas Spock; Perry, Frank A. Belmont; Philadelphia, ; Potter, Francisco B. Villa; Schuylkill, ; Somerset, Alexander Solosko; Susquehanna, Paul B. Kerr; Tioga, William Reich; Union, Joseph Weightman; Venango, Harry Kanhofer; Warren, Harold J. Reinhard; Washington, William H. Kittrell; Wayne-Pike, ; Westmoreland, Leslie S. Pierce; Wyoming, John S. Rinehimer, Jr.; York, Donald R. Gross.

Proposed Amendments to the Constitution and Bylaws

Printed below is the text of the amendments to the Constitution and Bylaws which are being proposed by the Committee on Constitution and Bylaws, with the exception of Subject Eleven, which is being proposed by the Board of Directors of the Philadelphia County Medical Society and in accordance with Article XIV of the Constitution. Material in italics is being added; material in brackets is being deleted. The Secretary's Notes include the vote required and the origin of the proposal.

Subject One

1. Effective date of terms of delegates to PMS House of Delegates.

Bylaws

Chapter XVI - Component Societies

Section 10. Delegates to this Society. Each Component Society shall at some meeting held prior to [June 1] *December 31* of each year elect, from among its members who are Active, Senior Active, Intern or Resident Members of this Society, delegates and alternates to the House of Delegates of this Society in accordance with the provisions of Article VI of the Constitution. [A Component Society may, if it so desires, hold the election of such delegates and alernates during the preceding year. In such event the] *The* Bylaws of the Component Society shall contain appropriate provisions for determining the manner in which the elected delegates and alternates shall be reduced should they prove to be a number in excess of those to which the Component Society is entitled on the basis of the number of its members as of December 31 of such preceding year, and appropriate provisions for the designation [prior to June 1] of additional alternates and delegates should the Component Society be entitled to more than those elected at the earlier election *on the basis of the number of its members as of December 31.*

(Secretary's Note: Three-fourths vote required. Committee recommendation.)

Subject Two

II. Judicial Council eligibility qualifications.

Constitution

Article IX - The Judicial Council

Section 6. Qualifications of Members. No member of this Society shall be eligible for election to the Judicial Council unless: (a) he has served as (i) a President of this Society; or (ii) a member of the Board of Trustees and Councilors for at least one full term; or (iii) [a member of the House of Delegates for at least five years;] *a member of the House of Delegates personally registered and in attendance at least at one session of the House of Delegates per year for a minimum of five years;* and (b) he shall not be a member of a Component Society, a member of which (i) is then serving as a member of the Judicial Council and whose term will continue during any portion of the period for which the new member is to be elected, or (ii) has previously been elected to the Judicial Council at the same election. Notwithstanding qualifications as set forth above, no person shall be eligible to serve for more than three consecutive terms, but a member elected to serve an unexpired term shall not be regarded as having served a term unless he has served more than one year, and for this purpose a year shall be deemed to be the period between Annual Sessions of the House of Delegates.

(Secretary's Note: Two-thirds vote required. Committee recommendation.)

Subject Three

III. Resident physician section, medical school section, and associate members in House of Delegates.

Constitution

Article VI - House of Delegates

Section 2. Composition. The House of Delegates shall be composed of (a) delegates (or their alternates) elected by the Component Societies in the proportion of one delegate for every one hundred or fraction thereof of its Active, Senior Active, *Associate*, Intern and Resident Members in this Society whose dues are paid or excused as of December 31 of each preceding year, whose term of office shall be for a term of one year or for a term in excess of one year if such Component Society's Bylaws provide for a longer term than one year provided that at least one delegate or alternate be elected by such Component Society each year, and whose names have been submitted to the office of the Executive Vice President of the Pennsylvania Medical Society as instructed by the Executive Vice President, and in January of each year the Executive Vice President of the Pennsylvania Medical Society shall certify to each Component Society the number of delegates to which it is entitled during the current year; (b) the secretaries of the Component Societies in office at the time of any meeting of the House of Delegates; (c) specialty [section] members, delegates elected by the American Medical Association Board certified specialties having organized societies in Pennsylvania on the basis of one delegate for each such specialty society, such specialty delegates shall be Active, Senior Active, *Associate*, Intern, or Resident Members in good standing in this Society; (d) special student members (or their alternates) as defined in Sections 9 and 10 of Article IV: and *(e) a residents' delegate or alternate of the section of residents as described in the Bylaws, Chapter XVII, Section 1; (f) a medical school section delegate of the section of medical schools as described in the Bylaws, Chapter XVII, Section 2;* [(e)] *(g)* ex-officio but without the right to vote, the Speaker, Vice Speaker, and Immediate Past Speaker of the House of Delegates, the President, President Elect, and Vice President, the Secretary, the Trustees and Councilors, and the members of the Judicial Council of this Society, the ex-presidents of this Society and the presidents of the Component Societies, except that any of the foregoing ex-officio delegates, other than those prohibited from so doing by Article V of this Constitution, may at the same time serve as voting delegates duly designated as such by the respective Component Societies, and except that the Speaker, or the Vice Speaker when serving as Speaker, shall have the right to vote in all cases where his vote would change the result of a vote taken other than a vote decided by ballot.

(Secretary's Note: Two-thirds vote required; 1977 House Action.)

Bylaws

Chapter III - House of Delegates

Section 4. Credentials of Delegates. Prior to the opening of any session of the House of Delegates, the Secretary of each Component Society, under the seal of the same, shall certify to this Society the names of each voting delegate and each alternate who has been legally and regularly designated as a voting delegate or alternate delegate to this Society. The Secretary of each specialty society in Pennsylvania shall certify to this Society the names of the voting delegate and alternate who has been legally and regularly designated as that society's voting delegate and

alternate to this Society's House of Delegates. Each Special Student Member or his alternate shall deposit with the Committee on Credentials a certificate signed by the Secretary of this Society under the Society's seal which states that he is the duly certified representative of his Chapter of the American Medical Students Association. *The secretaries of the resident physician section and the medical school section shall certify to the Society that each delegate is legally and regularly designated as that section's voting delegate or alternate to this Society's House of Delegates.* No voting delegate and no alternate delegate may be seated until the foregoing requirement has been complied with, provided, however, that the Credentials Committee may waive this requirement in unusual cases when satisfied that the person presenting himself as a voting delegate or alternate delegate is the person who has been certified as such to the Executive Vice President in accordance with the provisions of Article VI of the Constitution, or has been duly selected in accordance with Section 3 of Article VI of the Constitution of this Society. Prior to the opening of any session of the House of Delegates, the Executive Vice President shall certify to the Committee on Credentials the names of all members of the House of Delegates as shown on his official records. Such certification shall be sufficient for the seating of the secretaries or presidents of Component Societies and for the identification of the voting and non-voting members of the House of Delegates. Any dispute that shall arise as to the seating of any voting delegate or any alternate delegate shall be determined by the House of Delegates after a report thereon by the Committee on Credentials, and the action of the House in such cases shall be final.
(Secretary's Note: Three-fourths vote required; 1977 House Action.)

Subject Four

IV. Establishment of special sections.

Bylaws
Chapter XVII - Special Sections

Section 1. Resident Physician Section. Membership in this section shall include resident physicians who are members in the Resident category of the Pennsylvania Medical Society. The section shall elect a governing committee consisting of a chairman, vice chairman, secretary, delegate, and alternate delegate to the PMS House of Delegates, and two members-at-large. The regular functions of this section shall include, but not be limited to, the conducting of a business meeting held in conjunction with the PMS House of Delegates Session.
(Secretary's Note: Three-fourths vote required; 1977 House Action.)

Bylaws
Chapter XVII - Special Sections

Section 2. Medical School Section. Membership in this section shall include deans of Pennsylvania medical schools who are Active members of the Pennsylvania Medical Society and up to five members of administration or faculty of each Pennsylvania medical school, designated by the dean of the school, who are Active members of the Pennsylvania Medical Society; in the event the dean is not an Active member of this Society, the dean may designate a representative who is an Active member. The section will elect the governing council consisting of a chairman, vice chairman, secretary, delegate, and alternate delegate to the PMS House of Delegates, and two members-at-large. The regular functions shall include, but not be limited to, the conducting of a business meeting held in conjunction with the PMS House of Delegates Session. The cost incurred by the participating members of the section should not be a responsibility of the Pennsylvania Medical Society.
(Secretary's Note: Three-fourths vote required; 1977 House Action.)

Subject Five

V. Chapter XVII, Amendments to the PMS Bylaws - numeral change.

Bylaws
Chapter XVII - Amendments

[Chapter XVII.] *Chapter XVIII.* These Bylaws may be amended at any Annual Session of the House of Delegates by an affirmative vote of three-fourths of the delegates present after lying over one day. If there be a majority but less than a three-fourths favorable vote, the amendment shall lie over until the next session of the House of Delegates and the adoption thereof shall be in the manner and in accordance with the procedure for amendments to the Constitution.

These Bylaws may be amended at any special session of the House of Delegates in the same manner as amendments to the Constitution. The House of Delegates may determine the effective date of any amendment.
(Secretary's Note: Three-fourths vote required. Committee recommendation.)

Subject Six

VI. Conditions for termination-reinstatement.

Bylaws
Chapter I - Membership

Section 7. Termination of Membership. The membership of a member of this Society shall terminate (a) in the case of Active or Senior Active or Associate Members suspended pursuant to subsection (a) of Section 6 of this Chapter who have not completed the continuing medical education requirement for the AMA Physician's Recognition Award by the end of a one-year period of suspension; (b) upon (i) termination of membership in a Component Society for any reason whatsoever, or (ii) failure to pay a delinquent assessment within thirty days after notice of such delinquency as provided in Section 2 of Chapter IX of these Bylaws, or (iii) three months after ceasing to be eligible for membership herein in the class of membership in which he is a member as specified in the Constitution, unless at such time an application or certification for another class of membership for which the member will become immediately eligible is pending in the office of the Executive Vice President of this Society; and (c) upon the effective date, as provided in Section 7 of Chapter XIII of these Bylaws, of an order to that effect issued by the Judicial Council of this Society. [Any person whose membership has been terminated for failure to pay a delinquent assessment shall be reinstated to membership without any break in continuity of membership upon payment of the delinquent assessment in full before December 31 of the assessment year, and reinstatement by his Component Society, but no such member under any circumstances shall be considered to be an Active, Senior Active, Intern or Resident member in good standing during the period between January 1 of the year for which assessment was delinquent and the date of reinstatement for the purposes of any section of the Constitution or these Bylaws. Any Active or Senior Active dues-paying or Associate member whose membership has been terminated by reason of failure to meet the requirements for the AMA Physician's Recognition Award shall be reinstated to membership if, after meeting all the other requirements for reinstatement, he submits evidence that he has met all the requirements for such award for a current period and that at least one-third of the hours required were obtained during the current calendar year.]

Section 8. Reinstatement of Membership. Any person whose membership has been terminated for failure to pay a delinquent

assessment shall be reinstated to membership without any break in continuity of membership upon payment of the delinquent assessment in full before December 31 of the assessment year, and reinstatement by his Component Society, but no such member under any circumstances shall be considered to be an Active, Senior Active, Intern, or Resident member in good standing during the period between January 1 of the year for which assessment was delinquent and the date of reinstatement for the purpose of any section of the Constitution or these Bylaws. Any Active or Senior Active dues-paying or Associate member whose membership has been terminated by reason of failure to meet the requirements for the AMA Physician's Recognition Award shall be reinstated to membership if, after meeting all the other requirements for reinstatement, he submits evidence that he has met all the requirements for such award for a current period and that at least one-third of the hours required were obtained during the previous twelve months.

Any person whose membership has been terminated for failure to pay a special assessment shall not be reinstated until such special assessment has been paid.

(Secretary's Note: Three-fourths vote required; 1977 House Action.)

Subject Seven

VII. Deletion of delinquent dues provision.

Bylaws

Chapter IX - Assessment and Funds

Section 2. Delinquent Assessments. A member whose annual assessment or special assessment is not paid at the time mentioned in Section 1 above shall be delinquent and shall not be in good standing in this Society. No delinquent member shall be entitled to exercise any of the rights and privileges of membership in this Society during the period of his delinquency. *Delinquent assessment is either the annual or special assessment.* The Executive Vice President shall send a notice to each delinquent member within sixty days of the date such member becomes delinquent, stating the amount then due and the fact that unless such amount is paid within thirty days after the date thereof the membership of such member will be terminated automatically as provided in Chapter I of these Bylaws. [No member of this Society whose membership has been terminated as provided above shall be reinstated until his delinquent assessment has been paid.]

(Secretary's Note: Three-fourths vote required; 1977 House Action.)

Subject Eight

VIII. Revisions regarding continuing medical education.

Constitution

Article IV - Membership

Section 12. Continuing Medical Education Requirement. In order for an Active or Senior Active dues-paying or Associate Member of this Society to remain a member in good standing of the Society [after June 30, 1976,] he must show evidence of engaging in continuing medical education as prescribed by the Bylaws of this Society.

(Secretary's Note: Two-thirds vote required. Committee recommendation.)

Bylaws

Chapter I - Membership

Section 5. Continuing Medical Education Requirement. In order for an Active or Senior Active dues-paying or Associate Member of this Society to remain a member in good standing of the Society [after June 30, 1976,] he must have qualified for the American Medical Association's Physician's Recognition Award, which award is currently based upon a three-year qualifying period. Each Active or Senior Active dues-paying or Associate member once he has qualified for the American Medical Association's Physician's Recognition Award, must continue to qualify for such award in order to remain a member in good standing of the Pennsylvania Medical Society. [The Board of Trustees and Councilors shall, in accordance with procedures established by such Board, have the power to waive such requirements in those cases involving Active or Senior Active or Associate members of this Society serving temporarily in the Armed Forces or other Government service of the United States or prevented from the practice of medicine by reason of illness or disability or in such other cases as in its judgment such waiver should be granted. The Board shall waive such requirements upon application from any Associate member not actively engaged in the practice of medicine. Special student members are exempt from the continuing education requirement.] *The Board of Trustees and Councilors shall, in accordance with procedures established by such Board, have the power to waive such requirements in those cases involving members. Members may apply for a waiver in one of the following categories: 1) total and permanent -for those who are permanently retired; 2) waiver for a limited time - for those who are temporarily ill, disabled, in military service, etc.; 3) conditional waiver of the PRA - for those who provide evidence of continuing education that is acceptable in lieu of the PRA.*

(Secretary's Note: Three-fourths vote required. Committee recommendation.)

Subject Nine

IX. Terms of members on Standing Committee on Constitution and Bylaws.

Bylaws

Chapter XIV - Committees, Administrative Councils, and Commissions

Section 2. Standing Committees. (b) Committee on Constitution and Bylaws. The Committee on Constitution and Bylaws shall consist of (a) five voting members of the House of Delegates to be appointed annually by the Speaker of the House of Delegates prior to August 1 from the members already reported as members of the House of Delegates for the coming Annual Session of this Society, and (b) the Speaker and Vice Speaker of the House of Delegates, the Secretary, Legal Counsel, and the Executive Vice President as ex-officio members without vote. The Speaker may reappoint a delegate to the chairmanship of this Committee for a maximum of six consecutive years. [No member other than the Chairman may be appointed more than two consecutive years.] The term of a member of this Committee shall begin with the opening session of the annual House of Delegates meeting following his appointment and shall conclude immediately prior to the next annual meeting. This Committee shall constantly study the Constitution and Bylaws and recommend revisions and modifications necessitated by changing times, methods, or conditions. All proposals for amendments to the Constitution and Bylaws shall, wherever possible, be submitted to this Committee in advance by any proponent thereof for consultation and advice, and this Committee shall serve as the Reference Committee of the House of Delegates as provided in Section 9 of Chapter III of these Bylaws.

(Secretary's Note: Three-fourths vote required. Committee recommendation.)

Subject Ten

X. Associate members, rights and privileges.

Constitution

Article IV - Membership

Section 10. Rights and Privileges of Members, Including Voting Rights. All members of the Society have all the rights and privileges of membership except as otherwise provided in this Con-

stitution and Bylaws and except that neither [Associate nor] Affiliate nor Honorary Members shall have the right to vote or hold any office or to be members of any council, committee, or commission.

Each Special Student Member shall serve as a delegate in the House of Delegates with the right to vote and to serve on reference committees, with the exception of the Reference Committee on Constitution and Bylaws; but no Special Student Member shall have the right to hold any office or to be a member of any council, commission, or committee.

No member of this Society of any class shall have any direct vote in the affairs of this Society except as to such matters, if any, where such vote is required by the laws of the Commonwealth of Pennsylvania.

(Secretary's Note: Two-thirds vote required. 1977 House Action. See Subject Three.)

Subject Eleven

XI. Terms of office - Board of Trustees and Councilors.

Constitution

Article VIII - Board of Trustees and Councilors

Section 2. Composition. The Board of Trustees and Councilors shall consist of the President, the President Elect, the Vice President, and the Immediate Past President, ex-officio with the right to vote, and the Speaker and the Vice Speaker of the House of Delegates, ex-officio without the right to vote, and one Active, Senior Active, Intern or Resident Member from each Councilor District of this Society as determined by the Bylaws. Each Trustee and Councilor shall be elected for a term of [five] *three* years and shall serve until his successor shall have been elected and qualified. No Trustee and Councilor shall serve more than two consecutive terms, but a member elected to serve an unexpired term shall not be regarded as having served a term unless he has served more than two years, and for this purpose a year shall be deemed to be the period between annual sessions of the House of Delegates.

(Secretary's Note: Two thirds vote required. Proposed by 18 active members of the Philadelphia County Medical Society.)

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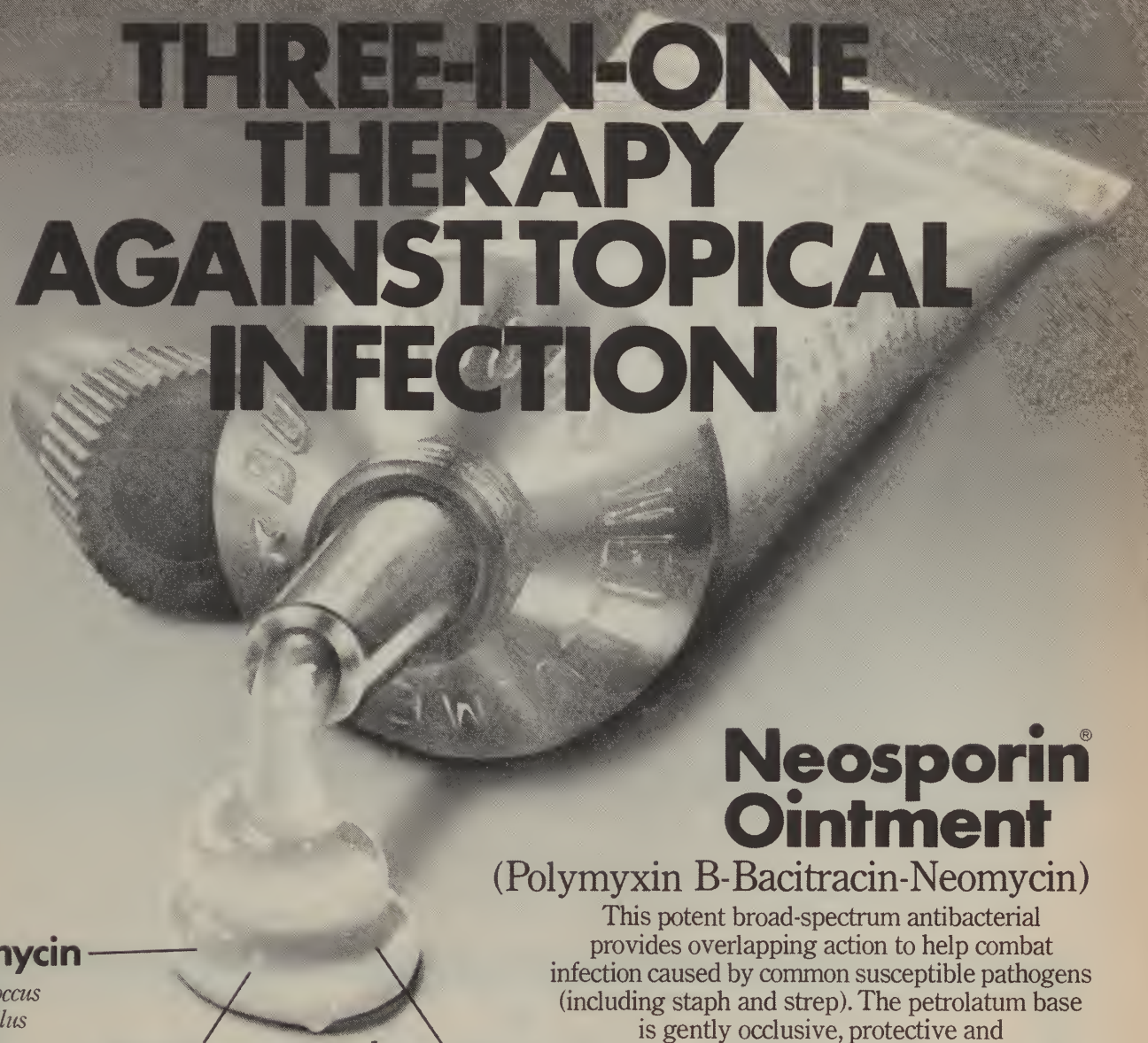
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WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.

*

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Riboflavin (B-2) . . . . . 2 mg.
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Riboflavin (B-2) . . . . . 2 mg.
Pyridoxine HCL (B-6) . . 10 mg.
In a special base of prolonged therapeutic effect.
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AVAILABLE: Bottles of 100, 500.

Indications: For use as a vasodilator in the symptoms of cold feet, leg cramps, dizziness, memory loss or tinnitus when associated with impaired peripheral circulation. Also provides concomitant administration of the listed vitamins. The warm tingling flush which may follow each dose of LIPO-NICIN 100 mg. or 250 mg. is one of the therapeutic effects that often produce psychological benefits to the patient. **Side Effects:** Transient flushing and feeling of warmth seldom require discontinuation of the drug. Transient headache, itching and tingling, skin rash, allergies and gastric disturbance may occur. **Contraindications:** Patients with known idiosyncrasy to nicotinic acid or other components of the drug. Use with caution in pregnant patients and patients with glaucoma, severe diabetes, impaired liver function, peptic ulcers, and arterial bleeding.

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Financial facts of life for physicians—part two

Leif C. Beck, LL.B., C.P.B.C.
Vasilios J. Kalogredis, J.D.

The authors continue last month's discussion of the importance to physicians of management-oriented financial statements.

Last month we began this two-part series by describing the significance of a weekly report. The importance of a management-oriented monthly financial statement was stressed.

This month's article will focus on the financial information a physician and his advisors should have available on a regular and timely basis. Figure 1, which represents a sample in-house monthly financial statement, will be referred to throughout this article. Its specific categories and format are not the best for all practices, but the basic concepts of the form can and should be applied by all practices for development of the best possible in-house financial report.

Financial information

Charges (productivity)—Charges are an important management tool that normally are not provided in practices' accounting statements. Because most accounting reports are geared primarily to tax return preparation, they often ignore charges that do not directly affect income taxes in the typical "cash basis" medical practice.

This is a great deficiency in the normal accounting reporting processes. Charges provide the practice with figures to help determine trends within the practice. In addition, charges are necessary in the preparation of the collection ratio and in keeping a "running score" on the accounts receivable of a practice. Both of these aspects will be discussed later in this article.

Page two of the sample monthly financial statement breaks down charges of the two hospitals, the main office, and the satellite office. In addition, it breaks down the charges of the two doctors and ancillary personnel producing income. These were the relevant pieces of productivity information in this particular practice. Other practices may find that productivity should be broken down into different categories. The important thing is for each practice to decide what charge information is needed and then provide for it.

More and more group practice physicians divide their income at least partially on productivity elements tied to charges. Obviously, in those instances, it is most important that the charges are segregated by doctor.

Some physician groups may protest that keeping track of each doctor's production might be divisive, but such information often diminishes differences in a group. If one physician continually produces less, he and his partners should either openly recognize that he contributes more to the practice in other ways or else decide on an income division formula that reflects this. Such differences often surface and all parties are better served when facts and figures are available on a running basis.

The authors are the principal consultants of Management Consulting for Professionals, Inc., Bala Cynwyd.

Receipts—Receipts are summarized in all accounting reports. We recommend, however, that they be broken down into "office receipts" (moneys received at the time of service) and "mail receipts" (all others). Note that the suggested monthly financial statement provides for these receipts.

Collection ratio—Most practices are unaware of their legitimate collection ratio. It is not difficult to compute. Practice receipts are divided by practice net charges (those reduced by Blue Shield, medicare, and Medical Assistance disallowances for which the patient cannot be billed). Page two of the suggested monthly report lists these disallowances as well as the collection ratio for the month and year to date. This important information allows a practice to keep on top of things. National averages show that collection ratios of between 93 and 96 percent are the norm.

Accounts receivable—Accounts receivable are generally not provided by accountants in practices' accounting statements. The sample statement provides space for listing the accounts receivable figure, as well as the amount written off, in a particular month.

An adding machine tape should be run of all outstanding accounts to determine a starting figure. Once the

PAGE 1
M.E. Surgical Associates, Ltd.
Monthly Financial Statement for _____, 19___

	This Month	Year-To-Date	Ratios; Comments	Budgeted for Year
Total Charges (per page 2)	$	$		$
Receipts:				
Office:	$	$		$
Mail:				
Total Receipts	$	$		$
Expenses:				
Lay payroll (Gross)	$	$		$
Payroll taxes				
Rent				
Prof'l supplies				
Prof'l insurance				
Office supplies & expenses				
Professional fees				
Total Overhead	$	$		$
Doctors' Expenses:				
Salaries				
Pension				
Profit sharing				
Medical expense plan				
Insurance				
Total for Doctors	$	$		$
Total Expenses (except depreciation & interest)	$	$		$
Net Income	$	$		$

PAGE 2
M.E. Surgical Associates, Ltd.
Supporting Information for _____, 19___

	This Month	Year-To-Date
Charges:		
Hospital #1	$	$
Hospital #2		
Main office		
Satellite office		
	$	$
Dr. M.	$	$
Dr. E.		
Ancillary personnel		
	$	$

Checking balance at month-end $_____
Savings balance $_____
Special savings earmarked:

Large bills due soon:

Overhead for month _____%
Overhead year to date _____%
Accounts receivable $_____
(Written off this month –$_____)

	Month	Year
Collection ratio	_____%	_____%
Blue Shield disallowances	$	$
Medicare disallowances		
Medical Assistance disallowances		
Major procedures:		
At Hospital #1		
At Hospital #2		
Minors:		
At Hospital #1		
At Hospital #2		

Other Information or Comments:

figure is reached, it is easy to add monthly charges and subtract monthly receipts and write offs to achieve a realistic accounts receivable figure. Periodically (at least twice a year) an adding machine tape should be run on outstanding accounts as a check against the monthly summary total that is run on the financial statement. If there is a large disparity between the two, there may be a problem.

Many practices have recovered account cards that otherwise may never have been billed. For example, if the monthly summary indicates that accounts receivable should be $100,000 and an adding machine tape of the outstanding account cards shows that only $88,000 is outstanding, there is a problem: someone has been embezzling, cards have been lost or misfiled, or a very serious mathematical error has occurred. The possibility of discovering these serious errors makes this "accounts receivable balancing" an important and necessary part of any well-run medical practice.

Expense—Practice expenses should be summarized. The monthly financial statement sample breaks down overhead into several categories (many practices will have others) and segregates the doctors' expenses portion of the overhead—doctors' salaries, retirement plan contributions, medical benefits, insurance benefits—for information purposes.

Expense information can easily be gathered from a check register which provides columns for the breakdown of expenditures within a practice. One feature of the pegboard checkwriting system is that it can be done under a "write it once" approach which avoids duplication. The staff, rather than an accountant, can easily do the posting. From the check register, it is easy for the bookkeeper to summarize expenditures by category on a monthly basis and enter them on the monthly financial report.

Overhead ratio—The practice's overhead ratio is calculated by divid-

ing all the practice's expenses (excluding doctors' expenses as defined above) by the practice's receipts. Note that on page two of the sample there is room for the overhead percentage for the month and year to date. Here again, trends can be determined and the figures are readily available for comparison with other practices.

The Society of Professional Business Consultants (SPBC) publishes an annual census summary of relevant charge, receipt, and expense items by specialty. We find these figures helpful for comparison purposes. If a practice is dramatically higher or lower than the norm, a critical evaluation becomes necessary. This evaluation is made easier by the availability of a simplified and current financial report.

Miscellaneous—The financial report should have spaces for checking and savings account balances. If savings funds are specifically earmarked (for example, retirement plan contributions, malpractice insurance premiums, and the like) they should be so designated. Large bills that are due should be listed on the report.

A space for special comments from the bookkeeper or office manager is useful and may encourage important observations (e.g., the lease may be up for negotiation, malpractice premium due in a month, etc.).

Note that on the first page of the report everything is broken down for "this month" and for "year to date." In addition, ratios (e.g., payroll as a percentage of gross receipts) can be listed. The final column on that page provides for a "budgeted for the year" figure for each item. This allows regular comparison of actual to budgeted from month to month to see if finances are in line with what was anticipated.

For more information about preparing a practice budget, see "Three Ideas to Improve Your Office Procedure" in the April 1975 issue of PENNSYLVANIA MEDICINE.

Every physician must decide what information is most important to him so that he can be kept informed and so that his advisors have the tools necessary to assist him in making decisions. The common problem of discussing practice matters in a vacuum can and should be avoided. □

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DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy,* Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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Consultation/Liaison Psychiatrist—For inpatient, outpatient psychosomatic service at university hospital with faculty appointment in medical college. Clinical, teaching and research skills required. Write to Paul J. Fink, M.D., Department of Psychiatry & Human Behavior, Thomas Jefferson University, 1025 Walnut St., Philadelphia, PA 19107. Affirmative action/equal opportunity employer.

Diagnostic Radiologist—Board certified. Nuclear medicine, ultrasonography and angiography experience needed. Community hospital in Philadelphia. Immediate opening. Locum tenens acceptable until permanent associate is obtained. Write Department 789, Pennsylvania Medicine, 20 Erford Rd., Lemoyne, PA 17043.

Psychiatrists—Board certified or eligible. Immediate openings. Good salary. Excellent benefits. Residence available. Located in central Pennsylvania within minutes of I-80 and I-81. Pennsylvania license required. Call (717) 275-7201 or write to Mr. Donald Campbell, Acting Superintendent, Danville State Hospital, Danville, PA 17821. An equal opportunity employer.

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Associate Pathologist—Board certified pathologist wanted to join a two-man department in a community hospital (261 beds). Medical school affiliation. For further information please contact Carlos Moreno, M.D., Chairman, Department of Pathology, St. Agnes Medical Center, 1900 S. Broad St., Philadelphia, PA 19145.

Family Practice—Board certified/eligible family practitioner needed by large multi-specialty group in northwest Ohio. Perfect opportunity for right individual to establish satellite practice in conjunction with a well-established large group practice. Top salary and fringes being offered as a member of the group along with other corporate benefits. Please forward curriculum vitae, salary requirements to Box 786, Pennsylvania Medicine, 20 Erford Rd., Lemoyne, PA 17043.

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Emergency Medicine Positions—Available with fee-for-service group throughout Pennsylvania, New York, New Jersey, and southeastern U.S. including all suburban, rural, and metropolitan areas. Minimum guarantee provided. Malpractice paid. Physician directors also desired. Send resume to NEEMA Emergency Medical Associates, 500 Spruce St., Philadelphia, PA, 19106; (215) 925-3511.

Primary Care Physician—Wanted for McAlisterville clinic in rural northern Juniata County, 45 minutes from Harrisburg, Pennsylvania. Income guarantee and malpractice; rent free office available. Associated with a university affiliated teaching program. Subspecialty support and other institutional resources provided on a rotating basis. Contact David A. Smith, M.D., Polyclinic Medical Center, 2601 N. Third St., Harrisburg, PA 17105; (717) 782-4130.

Orthopedic Surgeon Wanted—Associate for well established Orthopedic Clinic in Eastern Pennsylvania. First year, salary plus percentage. Partnership after one year. Board eligibility required. No investment needed. Write Department 709, Pennsylvania Medicine, 20 Erford Rd., Lemoyne, PA 17043.

Physicians—Consider a real change of pace! Accept a commission as an officer of the Pennsylvania Army National Guard. Serve one weekend each month and two weeks this summer. Benefits include continuing professional education, non-contributory retirement plan, full military pay, and a great deal of enjoyment and satisfaction. Let the "Guard" become your hobby. Contact Major Gene Klynoot, Department of Military Affairs, Annville, PA 17003; (717) 783-3420.

FP/GP—For new family health center in southern West Virginia. Starting salary and fringe benefits at $46,000, malpractice insurance coverage. National Health Services Corps recruitment site. Rural, coal mining region. Call collect (304) 683-3318 or write Gulf Area Health Association, PO Box 279, Midway, W. VA. 25878.

Psychiatrist—Board certified or board eligible. Mental hospital in metropolitan area. Easy access to New York, Philadelphia, and close to Pocono resort area. Good salary with excellent fringe and retirement benefits. Residence available. Pennsylvania license required. Contact Henry Buxbaum, M.D., Superintendent, Clarks Summit State Hospital, Clarks Summit, PA 18411; (717) 586-2011.

House Staff Physician—265-bed accredited medical center seeks Pennsylvania Licensed Physician. Five and one-half days and every fourth night. Salary beginning at $32,000. Negotiable in accordance with experience. Many fringe benefits. Call or write Joseph M. Gambescia, M.D., Chairman, Department of Medicine, St. Agnes Medical Center, 1900 S. Broad St., Philadelphia, PA 19145; (215) 339-4450.

Diagnostic Radiologist—For 125-bed hospital. Contact Herbert S. Skuba, President, Ellwood City Hospital, Ellwood City, PA 16117; (412) 752-0081.

Emergency Physicians—A multi-hospital group of emergency physicians seeks members for full-time positions at major hospital emergency departments in Philadelphia and other areas of Pennsylvania. In addition to full-time emergency physicians, a physician director is sought for each emergency department. The group encourages professional and administrative autonomy in its member physicians. Financial arrangements are fee-for-service with minimum guarantee. Emergency-oriented educational programs for physicians are maintained by the group at no charge to its members. Compensation ranges from $40,000 to $60,000 per year for 48 hours per week. Write: Department 650, PENNSYLVANIA MEDICINE, 20 Erford Rd., Lemoyne, Pa. 17043.

Physician for Department of Emergency Services—200-bed general hospital in a beautiful university community located in western Pennsylvania. New construction and renovation program underway. Salary highly competitive. Pennsylvania license required. Contact William B. Yeagley, M.D., Director of Emergency Services, Indiana Hospital, Indiana, PA 15701; (412) 463-0261.

General Surgeon—Interested in teaching and practice of surgery in university-affiliated hospital in Philadelphia, PA. Send C.V. to R-67, PO Box 2066, Philadelphia, PA 19103. An equal opportunity/affirmative action employer.

POSITIONS WANTED

Certified Physician's Assistant—B.M.S.C. Pennsylvania native. Four years experience. Desires position with medical center or rural physician providing primary care in Pennsylvania. For resume write or call Robert Pyle, 1028 Mell Ave., Clarkston, GA; 30021; (404) 292-0494.

If You Need—A partner or associate; a physician to continue your practice upon your retirement; or a specialty physician for your hospital staff, contact PMS Physician Placement Service, Donna F. Wenger, Assistant Director Educational Activities, Pennsylvania Medical Society, 20 Erford Rd., Lemoyne, PA 17043; (717) 763-7151.

FOR SALE

Ophthalmology Offices—Due to sudden death of ophthalmologist, Hazleton, Pennsylvania. Excellent equipment and three outstanding locations. For experienced or new and ambitious physician. Will divide locations if necessary. Contact Charles M. Parsons, Assistant Trust Officer, Hazleton National Bank, Hazleton, PA 18201.

Internist's Complete Office Equipment and Furniture—All necessary items and accessories for two examining rooms. Secretarial, filing, and executive office equipment. Two years old. Must sell by September 1. Call (814) 437-1246.

Medical Office Space—In one of the top ten growth areas in entire country. We are just completing additional new office space at the Bunker Hill Medical Center in Washington Township, Gloucester County, New Jersey. Washington Township has a growth rate of approximately one thousand new homes each year. Write for list of present tenants, specialties, and local census figures. Some office space available for immediate occupancy. Send all inquiries to Hedenberg Bros., Inc., 199 N. Woodbury Rd., Pitman, NJ 08071.

Cape Cod: Falmouth—Doctor's suite and residence adjoining. Wooded acre overlooking harbor. Choice residential neighborhood in this year-round town of 20,000. Widow selling. Harold Bach, R.E. (617) 540-0707.

Active Eye Clinic—With 30 years background. Suitable as associate clinic for large medical institution or large industrial complex, also for HMO complex. Available at once. Call (215) 425-8343.

MISCELLANEOUS

Biomedical Electronics Service—Repairs medical, laboratory, and other electronic equipment. Will install and remove x-ray equipment. Walker Electronics, 143 North 9th St., Lebanon, PA 17042. Telephone (717) 274-3919.

CONTINUING EDUCATION

Cardiopulmonary Care II—Is the theme of the sixth annual seminar of the Central Pennsylvania Chapter for Respiratory Therapy. The program will be held at the Host Inn in Harrisburg, Pennsylvania on August 24 and 25, 1978 and has been approved for Category I Credit. The fee is $39 for AART members and $48 for nonmembers. Pre-registration is required. For more information contact: Continuing Medical Education, The Milton S. Hershey Medical Center, The Pennsylvania State University, Hershey, PA 17033.

Acid-Base and Electrolyte Seminar and Workshop—September 18-20, 1978. Cherry Hill Inn, Cherry Hill, NJ. Sponsored by Hahnemann Medical College. AMA accredited. A. B. Schwartz, M.D., program director. For more information, contact Continuing Education, Hahnemann Medical College, 230 N. Broad St., Philadelphia, PA 19102; (215) 448-8266.

Update Cardiology

Diagnosis and Treatment of Basic and Complex Tachyarrhythmias

October 12-13, 1978 Hotel Hershey

The Division of Cardiology, The Pennsylvania State University College of Medicine at The Milton S. Hershey Medical Center announces a postgraduate education series to update the practicing physician in current concepts in the diagnosis and management of patients with heart disease.

Educational meetings will be held to half day sessions to allow adequate time to enjoy the family activities available in the Hershey area.

***Guest Speaker:* George Will, nationally syndicated columnist, frequent contributor to *Newsweek* and commentator on the Washington scene. He will discuss "Jimmy Carter: The Most Restricted President."**

Registration for physicians—$75
Approved for six hours of AMA Category I Credit

For further information, contact:
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The Milton S. Hershey Medical Center
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Hershey, PA 17033
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For recurrent attacks of urinary tract infection in women

Bactrim™ DS Double Strength Tablets

Each tablet contains 160 mg trimethoprim and 800 mg sulfamethoxazole.



Just one tablet b.i.d. for 10 to 14 days

- Action at urinary/vaginal/lower bowel sites helps eliminate reservoirs of infecting organisms
- Distinctive antibacterial action plus wide spectrum helps eradicate recurrent UTI
- Low incidence of bacterial resistance in community practice
- Convenient *b.i.d.* dosage provides day-and-night antibacterial control
- Contraindicated during pregnancy and the nursing period. During therapy, maintain adequate fluid intake; perform CBC's and urinalyses with microscopic examination.

Before prescribing, please consult complete product information, a summary of which follows:

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli, Klebsiella-Enterobacter, Proteus mirabilis, Proteus vulgaris, Proteus morganii.* **It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination.** *Note:* The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

Also for the treatment of documented *Pneumocystis carinii* pneumonitis. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.

The recommended quantitative disc susceptibility method (*Federal Register,* 37:20527-20529, 1972) may be used to estimate bacterial susceptibility to Bactrim. A laboratory report of "Susceptible to trimethoprim-sulfamethoxazole" indicates an infection likely to respond to Bactrim therapy. If infection is confined to the urine, "Intermediate susceptibility" also indicates a likely response. "Resistant" indicates that response is unlikely.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers; infants less than two months of age.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

Urinary Tract Infections: Usual adult dosage—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days.

Recommended dosage for children—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. A guide follows:

Children two months of age or older:

Weight		Dose—every 12 hours	
lbs	kgs	Teaspoonfuls	Tablets
20	9	1 teasp. (5 ml)	½ tablet
40	18	2 teasp. (10 ml)	1 tablet
60	27	3 teasp. (15 ml)	1½ tablets
80	36	4 teasp. (20 ml)	2 tablets or 1 DS tablet

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	½ the usual regimen
Below 15	Use not recommended

Pneumocystis carinii pneumonitis: Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: *Double Strength (DS) tablets,* each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100. *Tablets,* each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40, available singly and in trays of 10. *Oral suspension,* containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole, fruit-licorice flavored—bottles of 16 oz (1 pint).

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Please see back cover.

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the Bactrim™ 3-system counterattack



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Bactrim has shown high clinical effectiveness in recurrent cystitis as a result of its wide spectrum and distinctive antimicrobial action in the urinary, vaginal and lower intestinal tracts.

The probability of recurrent urinary tract infection appears to be enhanced by the establishment of large numbers of *E. coli* or other urinary pathogens on the vaginal introitus. The trimethoprim component of Bactrim diffuses into vaginal fluid in effective concentrations, thus combating migration of pathogens into the urethra.

Studies have shown that Bactrim acts against *Enterobacteriaceae* in the bowel without the emergence of resistant organisms. Thus, Bactrim reduces the risk of introital colonization by fecal uropathogens. It has *no* significant effect on other normal, necessary intestinal flora.

Bactrim fights uropathogens in the urinary tract/vaginal tract/lower intestinal tract

Please see reverse side for summary of product information.

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Pennsylvania Medicine

Vol. 81, No. 9 SEPTEMBER 1978

Drugs

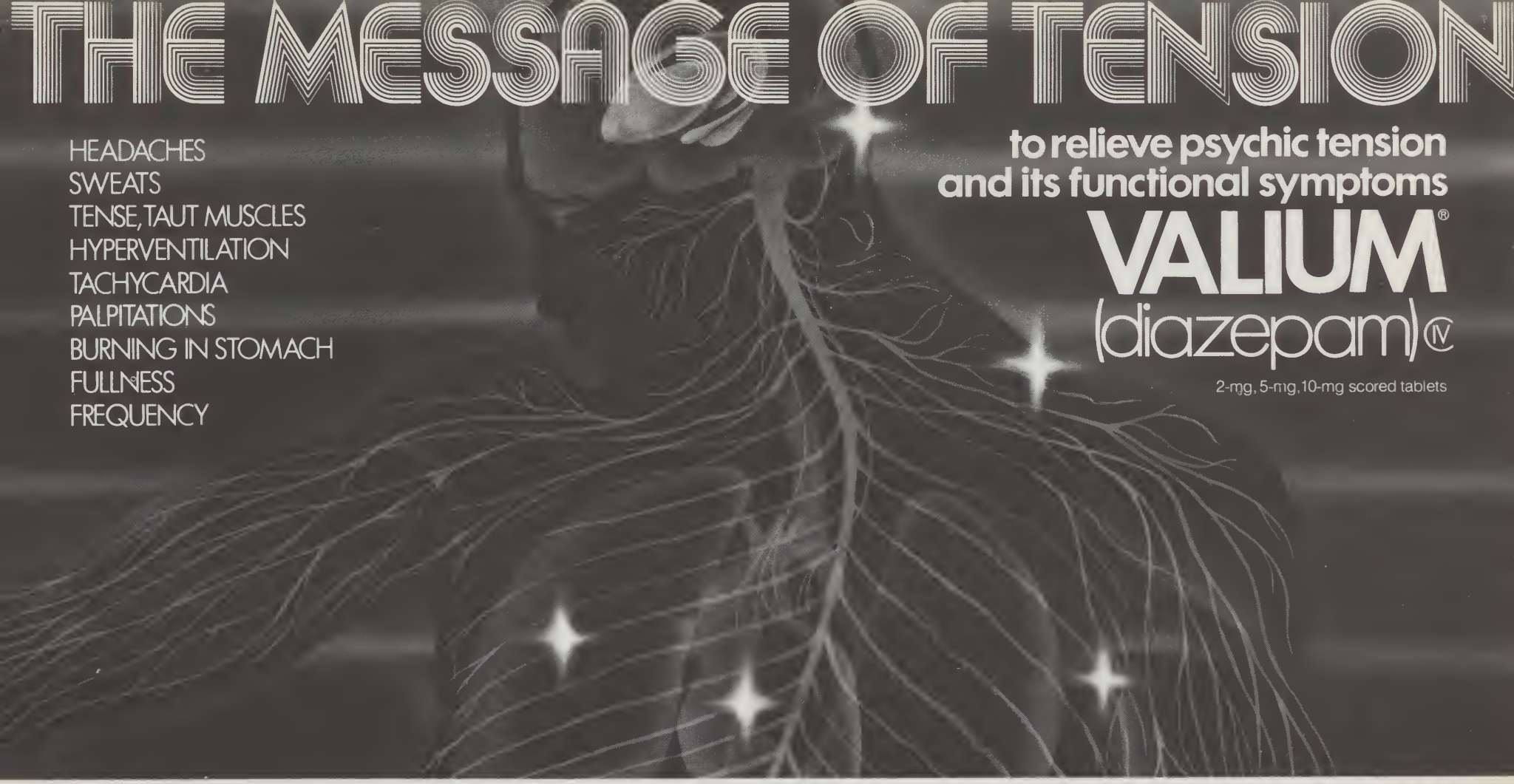
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to relieve psychic tension and its functional symptoms

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2-mg, 5-mg, 10-mg scored tablets

VALIUM®(diazepam)

Before prescribing, please consult complete product information, a summary of which follows:
Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).
The effectiveness of Valium in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.
Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**
Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.
Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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medigram

PMS BOARD AUTHORIZES SURVEYS ON MA PROGRAM

The PMS Board of Trustees at its August 23 meeting authorized two surveys proposed by the Medical Assistance Program Improvement Project. Management Consulting for Professionals, Inc., of Bala Cynwyd will be retained to collect information from physicians' offices to determine how the $6 fee paid for MA patient visits compares with the actual cost to physicians for the service. Harrisburg Hospital is authorized to collect data in its emergency room to determine the number and type of services rendered there which could safely and appropriately be provided in a physician's office at less cost. The committee is studying ways to improve the Commonwealth's medical assistance program.

NEW MEDICAL SCHOOL SUBJECT OF HEARINGS

The Society will testify September 6 at a public hearing on legislation which would convert Norristown State Hospital to a medical school. Additional hearings on the legislation are scheduled for September 22 and October 4. The September 6 hearing will examine the basic issue of whether more physicians are needed in Pennsylvania and whether the needs of people in areas of medical personnel shortage can be met with existing facilities.

SOCIETY TO SEEK LEGISLATION FOR CLINICAL LAB ACT RELIEF

On a recommendation of the Council on Education and Science, the PMS Board voted August 23 to seek amendments to the Clinical Laboratory Act to exempt offices of private practice physicians. The council has negotiated for a year with the Bureau of Laboratories in an effort to exclude from the licensing requirement offices of physicians who perform only a few tests. The efforts have had limited success.

BOARD OF TRUSTEES SETS POLICY ON CIGARETTE USE

The Society's Board of Trustees adopted a policy statement on cigarette use at its meeting August 23. The statement "recognizes the role of smoking as a public health hazard...and actively encourages...patient education efforts designed to minimize health risks attributed to smoking." It calls on physicians to establish personal health patterns which result in healthy living and to assist their patients to stop smoking by example and supportive encouragement. The Board also endorsed the Pennsylvania Cancer Plan developed by the Department of Health and voted to support the designation of tax monies from a cigarette tax increase for the cancer plan.

SOCIETY'S MEMBERSHIP NEAR 14,000 AT MID-YEAR

The Society's membership enrollment on July 31, 1978 was 13,921. A year ago, membership totalled 14,115. The membership department reported the slight decrease is the result of terminations for nonpayment of the mandatory assessment to establish the Pennsylvania Medical Society Liability Insurance Company. As of August 4, a total of $8,759,527 had been collected in assessments. Mandatory assessments paid by 12,352 members accounted for $2,818,800. Selective assessments totalling $5,940,727 were paid by 5,127 members. To date, 350 physicians have had memberships terminated for nonpayment of the mandatory assessment.

PMS SUBSCRIBERS REFUNDED 45% OF INSURANCE PREMIUM

A 45 percent refund totaling $83,729 will be returned to PMS members participating in the Society's Workmen's Compensation Insurance plan by the plan's administrators. The Dodson Insurance Group, Kansas City, MO, has refunded annually for five years an average of 41.5 percent of funds, or the equivalent of two years' premiums. More information on the Workmen's Compensation Insurance plan may be obtained from Riegel Haas, Director of Professional Relations, at PMS headquarters.

PMSLIC HEALTH GOOD AT SIX-MONTH CHECKUP

Six months after its birth the Pennsylvania Medical Society Liability Insurance Company's total capitalization stood at $8,700,000, according to a July 31 all-member letter from PMS President John V. Blady, M.D. Premiums received and deposited to PMSLIC as of July 14 amounted to $11,377,499. By June 30 the company had insured 5,280 physicians, of whom 3,606 had chosen occurrence policies and 1,674 had chosen claims made. Distribution of risks by premium class and territory was reported as follows: Class 1 (no surgery)--2,100; 2--718; 3--254; 4--702; 5--830; miscellaneous--676; Territory 1--1,611; 2--2,617; 3--824; 4--228.

BLUE SHIELD ADMINISTERS NEW SECOND OPINION PLAN

Pennsylvania Blue Shield has been named by the Department of Health, Education, and Welfare to operate in Pennsylvania the program to encourage second surgical opinions for elective, non-emergency surgery. Physicians wishing to participate in the program should contact Blue Shield to be added to the lists of physicians being kept by specialty and territory. Once the program is operational interested persons may call toll-free to receive two or three names of specialists in their area who are willing to offer a second surgical opinion. Reimbursement under medicare will be the usual payment received depending on the physician's Level I or the Level II ceiling. Payment for a medicaid consultation will be $6 unless the county assistance office authorizes a $10 payment to a specialist.

HEW FORCES WITHDRAWAL OF DPW HOSPITAL COST PLAN

The U.S. Department of Health, Education, and Welfare has forced the Pennsylvania Department of Public Welfare to withdraw temporarily its medicaid hospital cost containment plan. The plan would limit the interim reimbursement rate to a maximum increase of 12 percent of the previous year's per diem rate for medical assistance patients. The welfare department is working to revise four sections of the proposal in which HEW claims there are technical flaws and expects that HEW will approve the plan following completion of revisions.

NEW BLUE SHIELD PROFILES MEAN 8% FEE INCREASES

An increase averaging about 8 percent in Blue Shield's payments to physicians became effective July 1, 1978. New profiles, effective for services rendered as of that date, of doctors' usual (Level I) and customary (Level II) charges are based on actual claims for 1977 services. All PBS claims are processed according to profiles in effect on the date of service.

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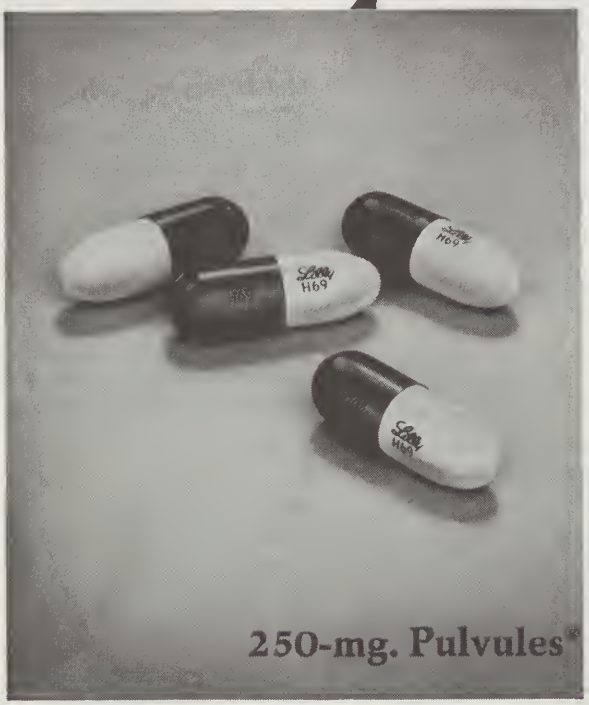
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Society president elect selects council members

The State Society Board of Trustees and Councilors has approved members of the four administrative councils, as selected by John B. Lovette, M.D., president elect of the Society. The following council members will serve during Dr. Lovette's 1978-79 term as president.

Council on Education and Science—Abram M. Hostetter, M.D. (Lebanon), chairman; David W. Kistler, M.D. (Luzerne), vice chairman;

Also, Gerald H. Amsterdam, M.D. (Philadelphia); William M. Cooper, M.D. (Allegheny); William E. DeMuth, Jr., M.D. (Cumberland); Frederick D. Fister, M.D. (Lehigh); Robert L. Folk M.D. (Montour); Michael A. Gross, M.D. (Lycoming); Arthur H. Hayes, Jr., M.D. (Dauphin); James J. Houser, M.D. (Venango); S. Victor King, M.D. (Blair); Charles L. Leedham, M.D. (Dauphin); Jay W. MacMoran, M.D. (Philadelphia); John H. Moyer, III, M.D. (Cambria); Robert N. Moyers, M.D. (Crawford); Hunter S. Neal, M.D. (Delaware); Herbert C. Perlman, M.D. (Cumberland); Paul C. Royce, M.D. (Bradford); William B. Yeagley, M.D. (Indiana); Nikitas J. Zervanos, M.D., (Lancaster).

Council on Legislation—R. William Alexander, M.D. (Berks), chairman; Charles K. Zug, III, M.D. (Northampton), vice chairman;

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Council on Member Services—William A. Shaver, M.D. (Lebanon), chairman; David F. Gillum, M.D. (Tioga), vice chairman;

Also, Brenda K. Baumann, M.D. (Dauphin); Leo J. Corazza, M.D. (Luzerne); Donald G. Crawford, M.D. (Dauphin); David S. Cristol, M.D. (Philadelphia); George E. Ehrlich, M.D. (Philadelphia); Samuel S. Faris, M.D. (Montgomery); Robert M. Laughlin, M.D. (Allegheny); Thaddeus Lekawa, M.D. (York); George J. Magovern, M.D. (Allegheny); Roldan G. Medina, M.D. (Fayette); Ernest J. Montgomery, M.D. (Armstrong).

The 1978-79 Membership Roster Edition of PENNSYLVANIA MEDICINE is now available. The roster contains component county medical society officers, component county society members with addresses and specialty codes, and an alphabetical listing of all members of the State Society and their county affiliations. Members may receive a complimentary copy by contacting the Membership Department, Pennsylvania Medical Society, 20 Erford Rd., Lemoyne, PA 17043. Additional copies are available for $30 each.

Dr. Regan heads internists



James R. Regan, M.D., of Bethlehem, was installed as president of the Pennsylvania Society of Internal Medicine at the society's 16th annual meeting in May.

Other officers elected for 1978-79 are Robert Kough, M.D., Danville, president elect; Howard Kremer, M.D., Philadelphia, treasurer; and Peter Hillyer, M.D., secretary.

Dr. Regan is a staff physician at St. Luke's Hospital and clinical associate professor of medicine at Temple University School of Medicine. He is past president of the Northampton County Unit of the American Cancer Society.

Radiologists elect officers

The Pennsylvania Radiological Society at its annual meeting in May elected officers for 1978-79. Bernard J. Ostrum, M.D., chairman of radiology at Albert Einstein Medical Center, Philadelphia, is the society's new president. He succeeds John H. Harris, Jr., M.D., of Carlisle.

Other officers are: Donald J. Ferguson, M.D., Pittsburgh, president elect; Joseph A. Marasco, Jr., M.D., Pittsburgh, first vice president; Carl Kaplan, M.D., Pittsburgh, second vice president; Robert Farrell, M.D., Scranton, secretary; Gene J. Triano, M.D., Harrisburg, treasurer; and Daniel G. Lareau, M.D., Warren, bulletin editor.

Councilors to the American College of Radiology are: Ronald A. D'Altorio, M.D., Pittsburgh; Joseph A. Marasco, Jr., M.D.; Robert E. Campbell, M.D., Philadelphia; George N. Stein, M.D., Merion Station; Theodore A. Tristan, M.D., Harrisburg; and Daniel G. Lareau.

Physician impairment confronted by special committee

Physician impairment has long troubled those who may encounter it in a colleague but are reluctant to interfere and those who fear it in themselves. A newly formed State Society committee is seeking to ease that reluctance.

Members of the Committee on the Impaired Physician, a special committee authorized by the Board in May, began implementing in June a comprehensive program of detection and rehabilitation for impaired physicians.

Named to the committee for their expertise on the subject of physician impairment are: Abraham J. Twerski, M.D., of Pittsburgh, chairman; Betty L. Cottle, M.D., Hollidaysburg; Allan J. Kogan, M.D., Philadelphia; Edward J. Resnick, M.D., Philadelphia; and Alfred P. Trescott, M.D., Wellsboro.

The committee's purpose is to "establish a statewide non-coercive program for locating, contacting, and offering rehabilitation help to physicians who have become functionally and professionally impaired to varying degrees because of alcoholism, drug dependency, mental, physical, and/or aging problems." Committee members serve as a peer review organization.

Because confidentiality is a cornerstone of the program, an unstaffed telephone line at State Society headquarters gathers initial calls. Callers hear a recorded message requesting name, address, telephone number, and general nature of the problem. The physician is not identified in the initial call.

Referrals, whether voluntary or involuntary, are answered by a member of the Impaired Physician Committee. In cases of self-referral, a committee member contacts the impaired physician, inquires about the problem, and discusses the physician's willingness to undertake appropriate treatment. The committee then assigns an intervention team which becomes an advocate for the physician being treated. At no time are members of the team involved in treatment.



Abraham J. Twerski, M.D., Pittsburgh, chairman of the State Society's Committee on the Impaired Physician.

When referral is made by a responsible source other than the impaired physician, a committee member gathers details of the case for committee evaluation. All information gathered by the committee is privileged and considered as protected confidentiality under Pennsylvania law, in keeping with the performance of a peer review function. When sufficient cause exists to justify contacting the physician, an intervention team is formed.

Further details about the program are available from the Impaired Physician Committee, Pennsylvania Medical Society, 20 Erford Rd., Lemoyne, PA 17043.

Impaired Physician Confidential Telephone Line: (717) 763-7937

Libel suit won by quackery opponent

A libel suit lodged against a York County chiropractor by Stephen Barrett, M.D., Allentown psychiatrist, recently was settled in favor of Dr. Barrett. The physician, who is chairman of the Lehigh Valley Committee Against Health Fraud and a member of the State Society's Committee on Quackery, received an award of $500 and a retraction.

At issue in the suit was a letter, written by James M. Sigafoose, a chiropractor, published in the Hanover *Evening Sun* last summer criticizing the paper's earlier publication of an article by Dr. Barrett that was critical of chiropractic. The article was condensed from a chapter on chiropractic in *The Health Robbers,* a book published by the Lehigh Valley Committee and edited by Dr. Barrett.

Sigafoose defended chiropractic and charged in the letter that: "Barrett is a psycho psychiatrist who has dedicated his life to witch hunting the chiropractic profession."

Dr. Barrett's libel complaint contended that the statements were "defamatory and libelous in that they falsely and maliciously ascribe to Dr. Barrett dishonesty, mental disability, and incompetence in his chosen profession."

Cost effectiveness a question mark

Blue Shield summarizes second opinion program

Brad Langdon

Early results from Pennsylvania Blue Shield's two-year-old surgical consultation program (SCP) indicate second opinions may reduce surgery rates. However, cost effectiveness remains a question mark.

In a summary presented to the Pennsylvania Medical Society's Board of Trustees, Robert B. Edmiston, M.D., Blue Shield's executive vice president for professional affairs, stressed that "caution must be exercised in drawing conclusions from the summary report. Because of the low volume of enrollment and utilization (of the program), the validity of the date is questionable." He added that at least one to three years of additional study will be required to verify the results.

Blue Shield began its surgical consultation program in January 1976 as an experimental project for its own employes and employes of Capital Blue Cross. Since then, active interest from management and unions has boosted eligibles from less than 6,000 persons to more than 133,000. But 90,000 of the eligibles joined only in the final month of the two-year period.

To date the program has experienced very low use of the second opinion option. Although 1,443 eligibles had elective surgery during the study period, only 46, or 3 percent of the eligibles, sought a second opinion. Of these 46 patients, however, 13, or 28 percent, were advised not to have surgery.

The negative recommendations affected the following procedures (all one time except as noted): varicose vein resection, excise lipoma, pin removal following fracture, excise bursa, excise lymph nodes, spinal surgery (2), arthrotomy, reconstruct knee joint, metatarsal surgery, mastotomy, hysterectomy, and arthrodesis (ankle fusion).

The author is a staff assistant in the State Society's communications department.

Hysterectomy was the procedure most frequently considered, and of the five originally recommended, four received second opinions supporting surgery. By surgical category, general surgery cases accounted for 33 percent (15) of the caseload, but only 7.5 percent (1) of the negative second opinions. The category of orthopedic surgery was second with 28 percent (13) of the caseload. Orthopedics, however, produced seven negative second opinions, more than half of all negative second opinions and half of all orthopedic cases considered.

Several factors appear to have kept the SCP utilization rate low. One reason was Blue Shield's decision not to market the benefit actively, but to allow the program to grow on its own merits. Blue Shield experience indicates that the utilization of the SCP benefit is directly proportional to the amount of promotion of the program to the eligibles by their respective employers.

Other reasons cited by Dr. Edmiston included the patient's "traditional, conservative confidence in the family physician or specialist with whom he has had a long term doctor-patient relationship." Some patients already had received lengthy medical treatment for a specific condition, and had made a personal decision to have surgery. Lack of physician familiarity with the program contributed to underutilization of the program. He said it required considerable follow-up work by Blue Shield staff to ensure claims were submitted properly.

The cost incurred by Blue Shield for the program may not be reflective of the true nature of a highly developed second opinion program. Dr. Edmiston said the Blue Shield project thus far has been a manual claims analysis and claims processing system. Each second opinion cost an average of $43.50 for consultation and diagnostic services. Broken down, physician charges for consultation ranged from $10 to $125, while charges for diagnostic services ranged from no charge to $70. Frequently, no diagnostic fees were charged because diagnostic data obtained for the first opinion were available to the consultant. Payments are determined by the UCR mechanism.

Dr. Edmiston said that although Blue Shield has not developed a cost effectiveness report based on this preliminary summary, he believes the evidence eventually will show that the Blue Shield SCP project might be cost effective.

Pa AAP meets planners

Child health care planning was the focus of a meeting of the health planning committee of the Pennsylvania Chapter, American Academy of Pediatrics June 3 at PMS headquarters.

Annette Lynch, M.D., director of the Bureau of Children's Services of the Pennsylvania Department of Health, and Jordon Ewell, commissioner of the Office of Planning and Development, were guests at the meeting.

Committee Chairman Joseph Weader, M.D., said the purpose of the meeting was to acquaint pediatricians with the health planning law and to allow members to report on HSA activity in their areas.

Medical investigators trained for factfinding mission

Twelve trainees with diverse backgrounds in health planning, nursing, and social science entered Shippensburg State College June 5 to begin intensive studies of medical practice and investigative techniques. Six weeks later, with help from the State Society, the state Department of Health, Blue Cross and Blue Shield, Hershey Medical Center, Dickinson School of Law, and several physicians, the college produced the state's first professional conduct (medical) investigators.

As employes of the state Bureau of Professional and Occupational Affairs, the new investigators are now qualified to seek evidence on complaints lodged against health care professionals licensed in the state. They will aid the State Board of Medical Education and Licensure through fact-finding interviews, review of medical records, detailed reports of findings, and testimony in administrative hearings. Previously Bureau investigators were responsible for 22 professions and occupations. Often they were unable to understand the technicalities of medicine. Physician specialists will be hired by the Board as part-time consultants to analyze data and explain complex medical problems.

The medical investigator program was initiated following a State Society suit against the Commonwealth for release of physician license fees to establish a conduct investigation unit. The $30,000 six-week course and the $12,000 salaries of the investigators are paid for entirely from physician license fees.

Investigator trainees were instructed in general education and basic skills, office and institutional procedures, medical fundamentals, medical practice, legal considerations, and investigative principles and procedures. Hospital field trips and videotaping of mock interviews supplemented classroom work.

State Society members and staff lectured classes on medical fundamentals and practice, including anatomy, physiology, and pharmacology; physician impairment and alcohol and drug abuse; standards of practice; peer review; medical/political organizations; medical ethics; and allied health professionals.

The medical investigators will serve only as fact finders for the State Board. Seven attorneys hired in May as medical examiners will hear cases as administrative law judges. Physicians will be able to appeal a medical examiner's decision to civil court.

Temple University Sports Medicine Center Runners Clinic

The Temple University Sports Medicine Center has established a Runners Clinic to help solve the many problems encountered by runners. We have brought together medical personnel, knowledgeable and interested in the problems of the runner. The Runners Clinic will be held Thursday afternoons, 1 p.m. to 5 p.m. During this time, analysis of the biomechanics of the lower extremity will be performed and the runner's gait observed while he runs on the treadmill.

Dr. Ray A. Moyer, director of the Sports Medicine Center, Dr. David L. Berman, podiatrist, Theodore C. Quedenfeld, athletic trainer, and other medical personnel are participating in the Clinic.

The Sports Medicine Center is located on the second floor of the Tioga East Building, Broad and Tioga Streets, with entrance located at Tioga and Watts Streets. Call (215) 221-2111 for appointments.

Cooperative effort will train physicians in ACLS

The Pennsylvania Chapter, American College of Emergency Physicians, and the American Heart Association, Pennsylvania Affiliate, are cosponsoring a cooperative project among specialty organizations to plan and conduct statewide physician training programs in advanced cardiac life support.

Representatives from six specialty societies, the American Heart Association, and the Pennsylvania Osteopathic Medical Association have formed a committee to develop strategy for conducting the courses. The specialties are: anesthesiology, cardiology (including pediatric cardiology), emergency medicine, family physicians, surgery, and thoracic surgery. Paul M. Peindl, M.D., an emergency physician from Beaver Medical Center, Beaver, heads the group.

"The project's goal is to make all physicians aware of the need for cardiac life support training and then to train as many physicians as possible," said Dr. Peindl. "Physicians should realize that patients can and do have cardiac arrests anywhere—from the waiting room to the operating room. That's why it's so important to get physicians from all specialties involved in life support training."

The Heart Association has been conducting ACLS courses throughout the state for three years. To date only a few hundred Pennsylvania physicians are certified in ACLS. However, with the new JCAH standards mandating cardiac life support training for all hospital medical staffs, a greater number of physicians will be needing instruction and certification.

ACLS trains the physician in the use of airway adjuncts, intubation, intravenous techniques, defibrillation, dynamic and static dysrhythmia recognition, and drug therapy. Upon completion of the two-day course, the physician is granted certification as a provider of advanced cardiac life support. The course is accredited by the American College of Emergency Physicians and the AMA for Category 1 CME credit.

Training courses are scheduled to begin by late fall. For more information, contact PaACEP headquarters, 20 Erford Road, Lemoyne, PA 17043; (717) 763-7151.

State pediatricians expand leadership

The Pennsylvania Chapter, American Academy of Pediatrics, recently elected two new officers to its executive committee. Thomas J. Martin, M.D., Danville, was elected alternate chairman of the chapter. He will serve a term of two years. Michael Krak, M.D., Munhall, was elected to a three-year term on the executive committee. Both are fellows of the American Academy of Pediatrics.

Other PaAAP officers are: Russell B. Puschak, M.D., Allentown, chairman; Louis J. Casale, M.D., Doylestown, secretary-treasurer; Lawrence A. Dunegan, M.D., Pittsburgh; and Charles R. Reed, M.D., Philadelphia.

The state chapter has also created three new committees to deal with child health care delivery. The Committee on Child Health Care Planning, chaired by Joseph Weader, M.D., Danville, will focus on the activity in local HSAs.

The Committee on Child Health and Community Programs, chaired by Alturo Hervada, M.D., Philadelphia, will deal with areas of child health such as nutrition and immunization.

The new Committee on Medical Education was created to monitor continuing medical education courses available to pediatricians and to create new scientific programs for CME accreditation.

The chapter office of the Pennsylvania Chapter, American Academy of Pediatrics, is located at 20 Erford Road, Lemoyne, PA 17043; (717) 763-7151.

Pennsylvania residents to meet in Lancaster

PMS members in residency training programs in Pennsylvania are invited to attend the annual business meeting and conference of the PMS Resident Physician Section (RPS) to be held at the Host Farm Resort Motel, Lancaster, on Saturday, October 29, 1978.

The theme of the conference is "How to Better Survive Your Residency." Presentations will include such subjects as physician stress, resident negotiations and peer organizations, and improving teaching skills.

Information learned by PMS-RPS delegates to the AMA-RPS annual meetings last June in St. Louis will be shared with those attending the business meeting and conference. Pennsylvania delegates to the AMA-RPS meeting were: A. Patrick Jonas, M.D., Hershey; Alan Sooho, M.D., Philadelphia; Jerris Hedges, M.D., Philadelphia; Diehl Snyder, M.D., Hershey; Robert Snyder, M.D., Danville; and J. Patrick Tokarz, M.D., Hershey.

For more information about the annual meeting, contact Brenda Baumann, M.D., Secretary, Governing Council, PMS-RPS, 20 Erford Rd., Lemoyne, PA 17043

A report from the Pennsylvania Medical Care Foundation

Prepaid health care primer for practicing physicians

Health Maintenance Organizations and Individual Practice Associations

Introduction

In response to a commitment on the part of the federal government, the Pennsylvania legislature, and consumer and labor groups to foster the development of the health maintenance organization (HMO) concept in the early 1970s, the Pennsylvania Medical Society organized the Pennsylvania Medical Care Foundation as the body of the Society responsible for HMO activities.

The 1977 PMS House of Delegates directed the Pennsylvania Medical Care Foundation to:

conduct a project to evaluate the feasibility of establishing alternative health care financing and delivery systems and to determine the need to design a plan for the development of a physician-operated program dedicated to the financing and delivery of physicians' services and to the professional control of the quality and utilization of those medical services.

The following report represents the Foundation's initial findings relative to the organization and operation of health maintenance organizations (HMO) and individual practice associations (IPA).

Background

The term "health maintenance organization" emerged in 1970 as part of the health strategy of the Nixon administration. HMO prototypes such as the Kaiser Foundation Health Plan appeared attractive since they seemed to have effectively addressed some of the problems of the cost of medical care and accessibility by removing barriers to early treatment and by providing financial incentives for delivering services effectively and economically.

The concept of a local and privately operated health care delivery and financing system with financial incentives for cost control appealed to the Republican administration. The federal government viewed HMOs as a means to control rapidly rising medicare and medicaid expenditures. The HMO concept was put forth as an alternative to a nationalized health care system.

Congress responded to the interest in expanding the HMO concept by enacting Public Law 93-222, the Health Maintenance Organization Act of 1973.

Definition of HMO

A health maintenance organization is not necessarily synonymous with "Kaiser," nonprofit, hospital ownership, closed panel group practice, salaried physicians, etc., but rather, can include any or all of these ingredients, as well as fee-for-service, for profit, solo practice, and non-ownership of hospitals.

An HMO may be defined as an organized health care system which combines the delivery and financing functions by assuming the responsibility for providing and/or making arrangements for the health manpower and facilities necessary to deliver an agreed upon set of comprehensive health care services to a defined population. These individuals and groups are enrolled voluntarily on an annual basis for a pre-negotiated fixed payment. Such a system contains a financial plan which directly involves providers in the risk of underwriting the cost of the benefit package offered by the HMO and provides an organizational and managerial structure to assure the legal, fiscal, public, and professional accountability of the HMO.

(Note: "Comprehensive" benefits may be defined as those usual benefits offered under present health insurance programs, plus benefits which will tend to remove financial barriers and encourage early treatment in an ambulatory setting, when medically appropriate.)

Definition of IPA

The Individual Practice Association (IPA) concept emerged out of the federal HMO Act of 1973. IPAs are intended to serve as a mechanism for fee-for-service private practitioners to participate in an HMO or to form their own physician-majority HMO while continuing to practice in their traditional settings.

An IPA may be defined as a partnership, corporation, association, or other separate and distinct legal entity organized and operated by practicing physicians. An IPA provides a mechanism for interested physicians to collectively enter into contractual arrangements with other parties, such as

HMOs, to provide an agreed upon range of medical services to a defined population for a predetermined fee.

Physicians who join an IPA may continue to practice in their traditional settings on a fee-for-service basis but must agree to certain conditions to become a member of an IPA. For example, conditions for membership in an IPA might include the following:

1. Agree to conduct the medical practice in accordance with the purposes and policies of the IPA as expressed in its articles of incorporation, bylaws, and resolutions adopted by the IPA's Board of Directors and/or membership
2. Agree to accept, as payment in full, any reimbursement for services provided under any contract the IPA has entered into with other parties
3. Agree to comply with the peer review procedures established by the IPA
4. Accept all or part of the financial risk for delivering medical services within a fixed budget

Membership in an IPA *does not* limit a physician's practice to the treatment of patients covered under an IPA contract.

Under present law, an IPA is a separate legal entity but does not qualify as an HMO. An IPA has direct responsibility for providing medical services while the HMO establishes the benefit package and enrolls subscribers. In effect, the HMO has the subscribers and the IPA has the services. Therefore, an IPA must contract with an HMO to serve HMO subscribers.

Models of HMO Organizational Structure

Based on the organizational relationship between an HMO and participating groups of physicians and hospitals, existing HMOs can be categorized into eight models.

Of the eight HMO models shown on pages 12-13, the first four have the differentiating characteristic that the medical group was formed and is operated for the exclusive purpose of treating HMO subscribers.

The HMO structure described in Model 8 represents an HMO associated with an IPA which provides a physician the opportunity to participate in a comprehensive prepaid health plan while maintaining an individual mode of private practice (solo, small group, fee-for-service, etc.).

Some believe that interest in the IPA concept is the result of two major trends which are of concern to practicing physicians: (1) the escalating cost of health care; and (2) the increasing involvement of non-physician groups in the financing and delivery of health care.

The IPA offers physicians a mechanism to become involved in the development as well as the operation of HMOs. An *Individual Practice Association* provides private practitioners a means for:

1. Competing with closed panel HMOs
2. Utilizing existing health care resources in the community and not requiring extensive capital investment for hospitals, clinics, etc.
3. Allowing an individual physician to maintain a private practice on a fee-for-service basis and still participate in a comprehensive prepaid health plan
4. Providing patients an HMO alternative which can preserve their present relationships with physicians, hospitals, etc.

Federal HMO Act

(P.L. 93-222 enacted December 29, 1973, amended by P.L. 94-460, enacted October 8, 1976)

The Federal HMO Act provides the following definitions:

1. **"Basic health services"** constitute a *minimum benefit package* which the HMO *must* provide and include:
   a. Physician services (including consultant and referral services)
   b. Inpatient and outpatient hospital services
   c. Emergency health services, as medically necessary
   d. Short-term (20 or less visits) outpatient evaluative and crisis intervention mental health services
   e. Medical treatment and referral services for abuse of and/or addiction to alcohol and drugs
   f. Diagnostic laboratory, and diagnostic and therapeutic X-ray services
   g. Home health services
   h. Preventive health services (including immunizations, well-child care from birth, periodic health evaluations for adults, voluntary family planning services, infertility services, and children's eye and ear examinations)

In addition, the HMO, *at its option*, *may* include any supplemental health services it wishes as part of its basic health services package.

2. **"Supplemental health services"** are *optional* and include all or part of the following:
   a. Intermediate or long-term care
   b. Vision care, not part of basic services
   c. Dental service
   d. Mental health services, not part of basic services
   e. Long-term physical medicine and rehabilitative services, including physical therapy
   f. Prescription drugs

3. **"Member"** is an individual who has entered into a contract with the HMO for defined health care services. (*Note*: The Foundation prefers to refer to persons enrolled in an HMO as *subscribers*).

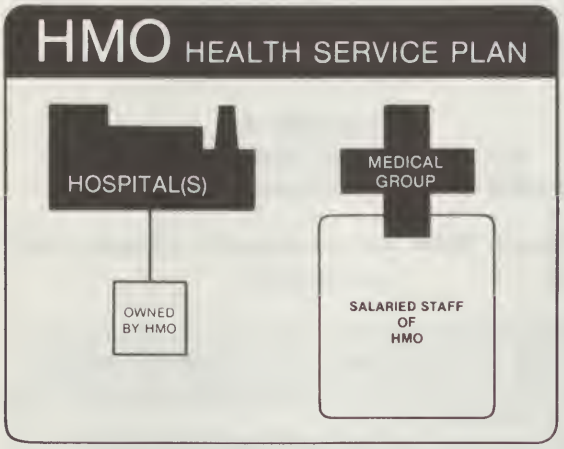
4. **"Individual practice association"** means a partnership, corporation, association, or other legal entity which has entered into a service arrangement (or arrangements) with persons who are licensed to practice medicine, osteopathy, dentistry, podiatry, optometry,

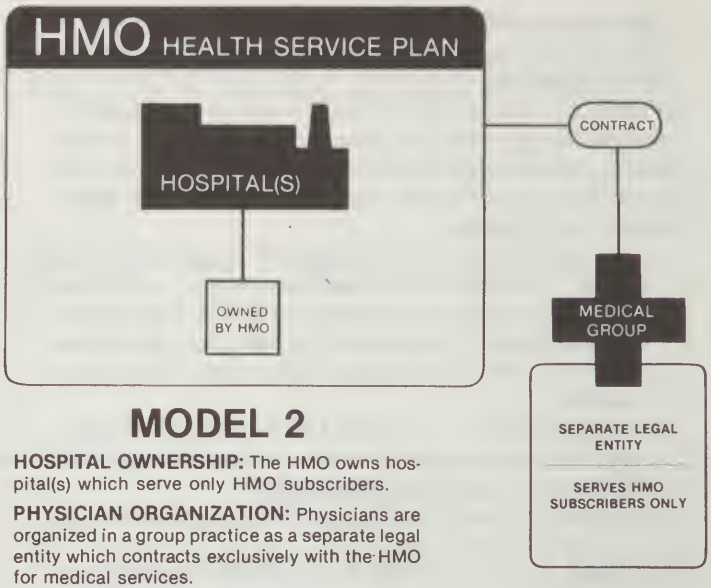
MODEL 1

HOSPITAL OWNERSHIP: The HMO owns hospital(s) which serve only HMO subscribers.

PHYSICIAN ORGANIZATION: Physicians serve the HMO in a group practice as salaried employees and serve the HMO exclusively.

EXAMPLE: Group Health Plan of Puget Sound.





MODEL 2

HOSPITAL OWNERSHIP: The HMO owns hospital(s) which serve only HMO subscribers.

PHYSICIAN ORGANIZATION: Physicians are organized in a group practice as a separate legal entity which contracts exclusively with the HMO for medical services.

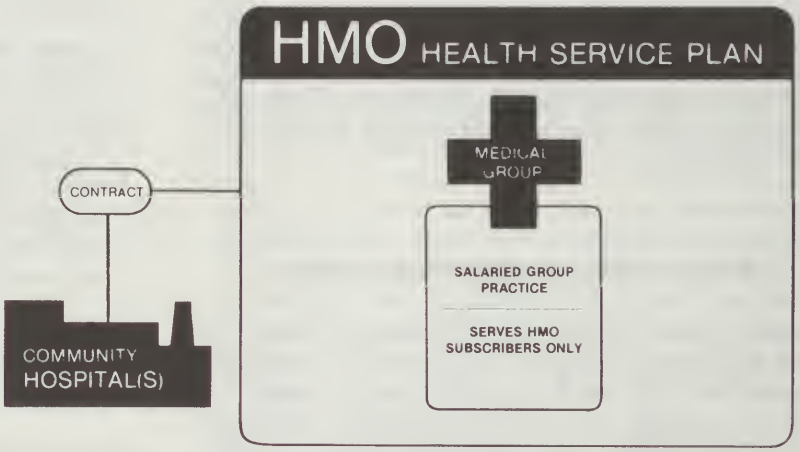
EXAMPLE: Kaiser Foundation Health Plan (Physicians are organized under the Kaiser Permanente Medical Group).

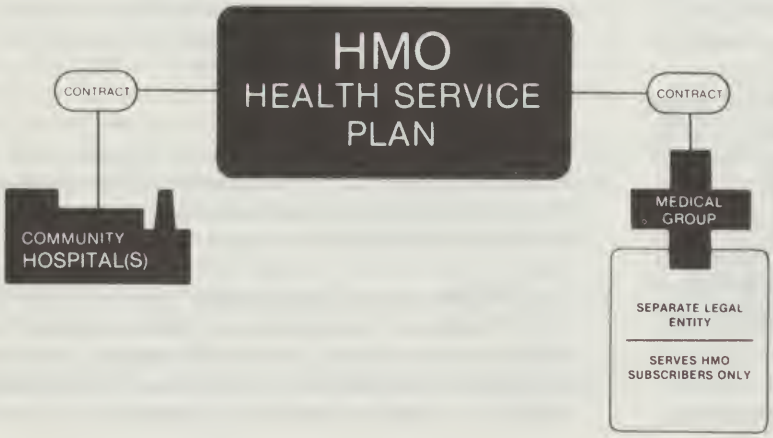
MODEL 3

HOSPITAL OWNERSHIP: HMO *does not* own hospital(s).

PHYSICIAN ORGANIZATION: Physicians serve as a salaried group practice of the HMO.

EXAMPLE: Group Health Association of Washington, D.C., and Harvard Community Health Plan.





MODEL 4

HOSPITAL OWNERSHIP: HMO *does not* own hospital(s).

PHYSICIAN ORGANIZATION: Physicians are organized in a group practice as a separate legal entity which contracts exclusively with the HMO for medical services.

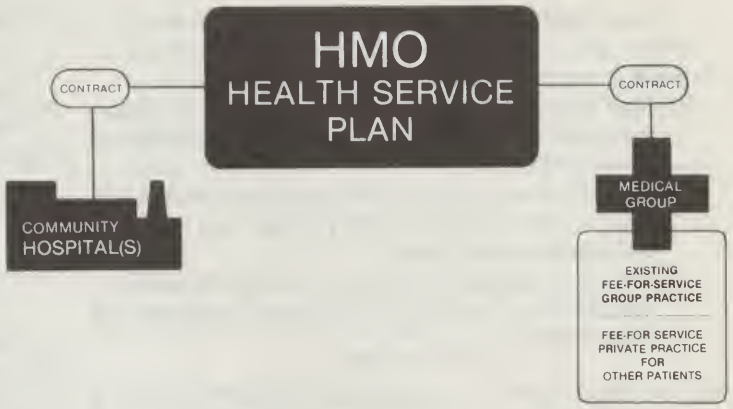
EXAMPLE: Health Service Plan of Pennsylvania (Philadelphia); Penn Group Health Plan of Pennsylvania (Pittsburgh); Kaiser Plan in Denver, Colorado; and Genesee Valley Group Health Association (Rochester, New York).

MODEL 5

HOSPITAL OWNERSHIP: HMO *does not* own hospital(s).

PHYSICIAN ORGANIZATION: Physicians are members of an established fee-for-service group practice which contracts with the HMO to provide some prepaid services to HMO's subscribers (members) while continuing a fee-for-service practice with other patients.

EXAMPLE: MedCenter Health Plan.

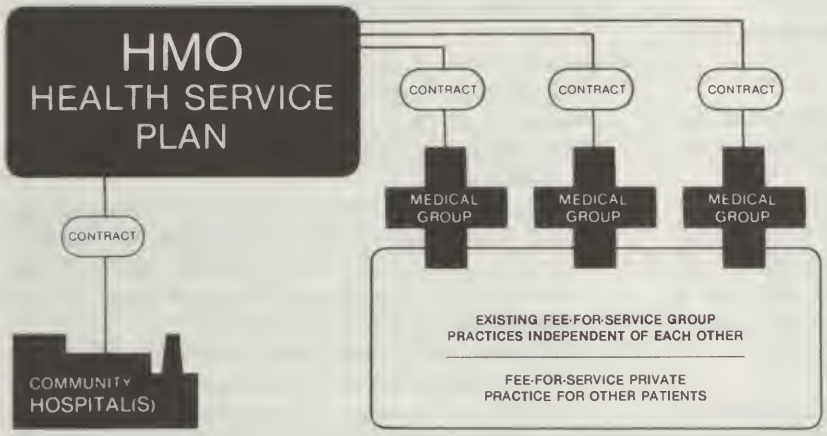


MODEL 6

HOSPITAL OWNERSHIP: HMO *does not* own hospital(s).

PHYSICIAN ORGANIZATION: Several established fee-for-service group practices contract, independent of each other, with the HMO to provide prepaid services to HMO subscribers (members) while continuing a fee-for-service practice with other patients. This is the group practice network concept.

EXAMPLE: Philadelphia Health Plan and Blue Cross of Chicago.

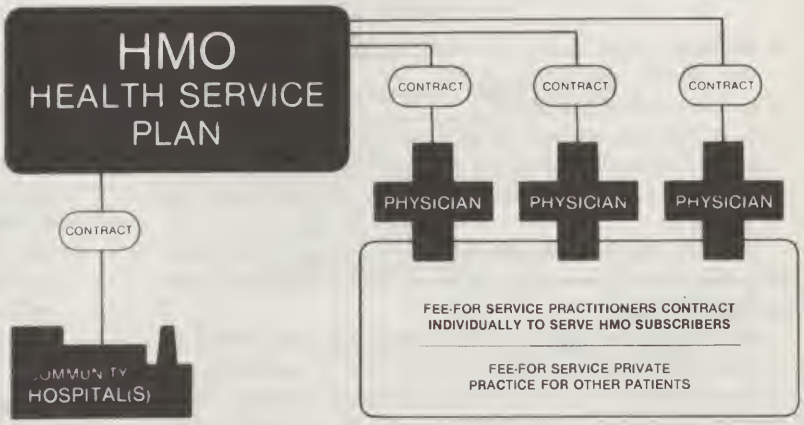


MODEL 7

HOSPITAL OWNERSHIP: HMO *does not* own hospital(s).

PHYSICIAN ORGANIZATION: Physicians continue to practice out of traditional settings (solo practice, small groups, etc.) on a fee-for-service basis and contract individually with the HMO to provide services to some HMO subscribers (members) while continuing to treat other patients.

EXAMPLE: Master Care (New Mexico) and Employers Mutual of Wausau (Wisconsin).



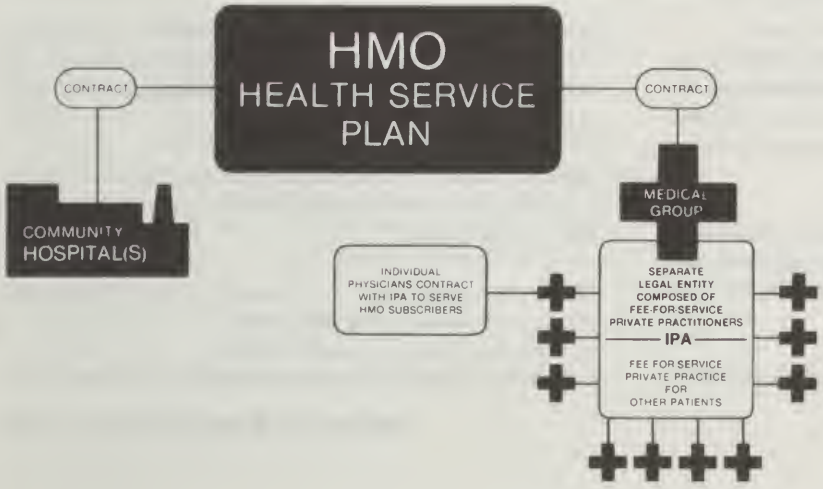
MODEL 8

(IPA-type HMO)

HOSPITAL OWNERSHIP: HMO *does not* own hospital(s).

PHYSICIAN ORGANIZATION: Physicians continue to practice out of traditional settings (solo practice, small group, etc.) on a fee-for-service basis but contract with the HMO to provide services to HMO subscribers (members) through a separate legal entity (Individual Practice Association—IPA).

EXAMPLE: Forbes Health Maintenance Plan of Pittsburgh and the Greater Delaware Valley Health Care, Inc.



or other health profession in a state and a majority of whom are *licensed to practice medicine or osteopathy*. Such an arrangement shall provide:

a. That such persons provide their service in accordance with a compensation arrangement established by the entity.
b. To the extent feasible, for the sharing of medical and other records, equipment and professional, technical and administrative staff
c. For the arrangement and encouragement of continuing education in the field of clinical medicine and related areas

The Federal HMO Act defines an HMO as a legal entity which:

1. Provides "basic health services" to its members for a premium which is:
   a. Paid on a periodic basis, and is
   b. Fixed under a community rating system (this requirement applies only to HMOs which have been qualified for more than 48 months)
   c. Nominal co-payments may be required at the time of service, except as they would serve as a barrier to utilization. Regulations of the Secretary of HEW will limit these strictly; they are intended solely as a device to enable an HMO to market its benefit package at a competitive price

2. *May* also provide "supplemental health services," either on a fee-for-service basis or on a pre-payment basis fixed on a community rating system.

3. Provides basic health services through health professionals who are members of:
   a. The staff of the HMO
   b. A "medical group" (or groups)
   c. An "individual practice association"
   d. Other health professionals under contract with the HMO

Basic services can be provided in a manner other than those described above when the services are required on an emergency basis.

Services provided as in 3(d) above cannot exceed 15 percent of the amount which the HMO will spend during the year for basic and supplemental health services. (The limit is 30 percent if the HMO principally serves a rural area.)

4. Provides services in a manner such that needed services are available and accessible promptly twenty-four hours a day and seven days a week and which assures *continuity of care*. This applies, or course, only within the HMO's service area.

5. Reimburses members for covered services rendered other than by the HMO in the case of medical *emergency* or when the member is *out of* the HMO's service *area*.

Furthermore, the Act requires that an HMO shall:

1. Be *fiscally sound*, with adequate provision against the risk of insolvency.

2. Assume *full financial risk* for providing basic health services, except that the HMO may *reinsure* for:
   a. Costs of basic services exceeding $5,000 for any member in any year
   b. Costs of emergency and out-of-area care
   c. Not more than 90 percent of the amount by which its costs for any fiscal year exceed 115 percent of its income for that year

3. Enroll persons broadly representative of the age, social, and income groups within its service area. However, not more than 75 percent of the membership can be drawn from a "*medically underserved area*" unless the area is also a *rural area*.

4. Have an *Open Enrollment Period* each year during which it shall accept individuals for membership in order in which they apply and without regard to their health status. This requirement is subject to the following conditions:
   a. It applies only to HMOs which have provided prepaid, comprehensive care for at least five years *or* have an enrollment of at least 50,000 members *and* which did not experience a financial deficit for the immediately preceding fiscal year
   b. The period shall be the lesser of 30 days or until the HMO has enrolled individuals equal to 3 percent of its total net increase in enrollment (if any) in the preceding fiscal year ("total net increase in enrollment" does not include individuals enrolled as part of a group which had a contract with the HMO when it became qualified)
   c. The HMO is not required to enroll individuals who are confined to an institution for an infirmity which would cause economic impairment to the HMO
   d. The HMO may impose a waiting period of up to 90 days before providing benefits to newly enrolled members
   e. The Secretary may waive the open enrollment requirement if the HMO demonstrates that open enrollment would jeopardize its economic viability in its service area

5. Not expel or refuse re-enrollment to any member because of his health status.

6. Have a policy-making board composed of at least one-third of the HMO's members and which equitably represents medically underserved populations served by the HMO.

7. Assure meaningful *procedures for hearing and resolving grievances* between the HMO (and its providers) and its members.

8. Have organizational arrangements for *an ongoing quality assurance* program which:
   a. Stresses health *outcomes* and
   b. Provides a review by the HMO health professionals

of the *process* followed in the provision of health services

9. Provide medical social services for its members and encourage and actively provide health education services, education in the use of the HMO's services, and education as to the contributions each member can make to the maintenance of his own health.

10. Provide for continuing education of its health professional staff.

11. Provide, subject to the Secretary's requirements and the need for confidentiality, an effective procedure for developing, compiling, evaluating, and reporting statistics and other information as to the HMO's:
    a. Cost of operations
    b. Patterns of utilization
    c. Availability, accessibility, and acceptability of services
    d. Developments in the health status of its members
    e. Other matters as required by the Secretary

The HMO receives the following benefits if it meets requirements for federal qualification:

1. Financial assistance for feasibility survey, planning, initial development and operational loans or loan guarantees.

2. State law overrides: (no application in Pennsylvania)
    a. Medical society approval of HMO
    b. All, or a percentage of, HMO governing body must be physicians
    c. HMO participation be open to all physicians
    d. HMO must meet state requirements for all health care insurers

3. Employers are mandated to offer employes a dual choice of each type of available HMO health service plan.

Pennsylvania Voluntary Non-Profit Health Service Act
(Act 364 of 1972)

Act 364 requires that a majority of HMO Board must be HMO subscribers or representatives of HMO subscriber groups and that *providers may not represent more than 10 percent of the Board composition.*

An HMO must be state-qualified to operate in Pennsylvania. The Pennsylvania Department of Health and, to a lesser degree, the Insurance Department prefer that HMOs qualify under Act 364 although there are other possible methods for an HMO to organize and operate in Pennsylvania. For example:
1. Blue Shield Enabling Act
2. Blue Cross Enabling Act
3. General insurance statutes (commercial)

Status of HMO Development

Nationwide, there were 180 HMOs (51 were federally qualified) at the end of 1977, serving about 6.5 million subscribers (members).

Shown below is a listing of the status of HMO development in Pennsylvania.

Operational HMOs:

The Philadelphia Health Plan
1015 Chestnut Street
Philadelphia, PA 19107

***The Health Maintenance Organization of Pennsylvania**
2500 Maryland Road
Willow Grove, PA 19090

***Health Service Plan of Pennsylvania**
#806 Bellet Building
1505 Race Street
Philadelphia, PA 19102

***Penn Group Health Plan, Inc.**
IBM Building
Pittsburgh, PA 15222

Geisinger Health Plan
Geisinger Medical Center
Danville, PA 17821

Centerville Health Plan
R.D. #1
Fredericktown, PA 15333

Central Medical Health Service
Central Medical Plaza
Pittsburgh, PA 15129

Greater Delaware Valley Health Care Plan
200 West Lancaster Avenue
Wayne, PA 19087

Forbes Health Maintenance Plan
500 Finley Street
Pittsburgh, PA 15206

***Federally qualified HMOs**

Prepaid medicaid contracts only: (At present)

Monsour Foundation Health Plan
70 Lincoln Way East
Jeannette, PA 15644

Physicians Health Services Plan, Inc.
230 North Fifth Street
Reading, PA 19601

HMOs in planning stage:

Eastern Pennsylvania HMO, Inc.
1503 N. Cedar Crest Blvd., Ste. 110
Allentown, PA 18104

Foundation Observations

Based on its initial evaluation of HMOs and IPAs the Foundation's Committee to Evaluate Alternative Health Care Financing and Delivery Systems has made the following observations:

1. There is a definite need to provide the medical profession with specific information on state and federal statutes and regulations relative to HMOs and IPAs; organizational options for HMOs and IPAs; and the current status of development.
2. The Pennsylvania Voluntary Nonprofit Health Service Act of 1972 (Act 364) *does not* permit a *physician-majority* HMO to organize and operate in Pennsylvania. An HMO must be certified by the state to operate in Pennsylvania.
3. The Federal Health Maintenance Organization Act of 1973 (P.L. 93-222), as amended in 1976 by P.L. 94-460, *does* permit the organization and operation of physician-majority HMOs.
4. Interested physicians in Pennsylvania should have the opportunity to organize and operate a physician-majority HMO.
5. The Foundation should pursue the following options to make it possible for physician-majority HMOs to operate in Pennsylvania:

   a. Seek enactment of legislation in Pennsylvania either by amendment of Act 364 or introduction of a separate bill
   b. Determine requirements to organize and operate under either the Blue Shield or Blue Cross enabling acts
   c. Consider the merits of purchasing a commercial insurance company

6. The Foundation should determine the availability of a federal grant for studying the feasibility of organizing physician-majority HMOs in Pennsylvania.
7. The Foundation should develop a model physician-majority HMO, using Model 8 as the prototype.
8. The Foundation should evaluate the need for developing a program to provide technical assistance to physicians interested in organizing an IPA-type HMO.

Continuing Education Programs 1978-1979

Institute for Medical Education and Research
Geisinger Medical Center

Management of Rheumatic Diseases - Update
Wednesday, September 20, 1978
9 a.m. to 5 p.m. Tuition: $40

Common Problems in Neurology
Wednesday, October 4, 1978
9 a.m. to 5 p.m. Tuition: $40

4th Annual Emergency Medicine Seminar
Wednesday, October 18, 1978
9 a.m. to 5 p.m. Tuition $40

Clinical Update in Gynecology
Wednesday, October 25, 1978
9 a.m. to 5 p.m. Tuition $40

Ophthalmology Update for Family Physicians
Wednesday, November 1, 1978
1 p.m. to 5 p.m. Tuition: $25

Clinical Advances in Pediatrics
Wednesday, November 15, 1978
1 p.m. to 5 p.m. Tuition: $25

Advances in Clinical Practice - 1979*
Saturday, Sunday, February 10, 11, 1979
9 a.m. to 5 p.m. Tuition $105

Office Treatment for Common Problems in Otolaryngology
Wednesday March 7, 1979
9 a.m. to 5 p.m. Tuition: $40

Endocrine Disorders of Pituitary, Pancreas & Parathyroid
Wednesday, March 21, 1979
9 a.m. to 5 p.m. Tuition: $40

Current Topics in Surgery
Wednesday, April 4, 1979
9 a.m. to 5 p.m. Tuition: $40

Advances in Dermatology for the Practitioner
Wednesday, April 18, 1979
1 p.m. to 5 p.m. Tuition: $25

As an organization accredited for continuing medical education, the Geisinger Medical Center certifies that these activities meet the criteria for credit hours in Category I of the Physician's Recognition Award of the American Medical Association. (Refer to each program — full day - 7 hours credit and ½ day - 4 hours credit).

For further information write to:
Millie K. Fleetwood, Ph.D.
Geisinger Medical Center
Danville, Pennsylvania 17821
or telephone (717) 275-6333



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- Vasodilan—compatible with your total regimen for vascular insufficiency

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Vasodilan injection, isoxsuprine HCl, 5 mg., per ml.

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Intramuscular: 5 to 10 mg. (1 or 2 ml.) two or three times daily. Intramuscular administration may be used initially in severe or acute conditions.

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Parenteral administration is not recommended in the presence of hypotension or tachycardia.

Intravenous administration should not be given because of increased likelihood of side effects.

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Legal counsel reports

Superior Court reviews grounds for malpractice suits

Fred Speaker, Esq.

In the closing days of 1977, the Pennsylvania Superior Court decided a medical malpractice case which established new grounds and reiterated others. In *Gradel v. Inouye,*[1] the court held in a sharply divided opinion that the trial court had erred in: (1) failing to advise the jury that the award would not be subject to federal income taxation; and (2) improperly instructing the jury that a physician's negligence in not taking x-rays could have been found to be responsible for later amputation of the patient's arm.

The case arose after the defendant properly treated a five-year-old boy's broken arm. During the year after the boy's discharge, his mother had him reexamined by the defendant three times because a lump of soft tissue had appeared and was increasing in size at the fracture site. Each time, the defendant declined to x-ray the arm because there was no pain, good motion and use, no unusual rate of healing, and the doctor feared overexposure by x-ray use. The boy's mother then took her son to an orthopedic surgeon, who took x-rays and performed an excisional biopsy which revealed a cancer of the bone—a fibrosarcoma of low grade malignancy. The orthopedic surgeon removed the remaining tumor and concluded that all cancer cells had been removed. This was not the case, however, for the cancer recurred and about a year later the boy's arm was amputated.

Mr. Speaker is a partner in the firm of Pepper, Hamilton & Scheetz, which serves as the Society's legal counsel.

At the trial, held some eight years after the amputation, the jury awarded the boy $700,000, made up of $180,000 for loss of his earning power and medical expenses and $520,000 for pain and suffering.

A significant factor in the size of the verdict appears to have been the argument of the boy's counsel that he would suffer from mental anguish through the rest of his life because of the fear of metastasis. Plaintiff's medical expert testified he had found that the cancer had not metastasized, although he had read of cases in which it had occurred much later than within two to five years. The boy had made no mention of fear of metastasis. Accordingly, the court held that the jury should have been instructed that the boy was entitled to no recovery on the possibility of later metastasis.

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In ruling on the issue of advising the jury that an award would not be subject to federal income taxation, the court departed from the prior holding of the Pennsylvania Supreme Court in *Girard Trust Corn Exchange Bank v. Philadelphia Transportation Co.*[2] In that case, the court stated:

> The majority rule in the United States is that in fixing damages for the determination of decedent's earning capacity, the income tax consequences of the matter should not be taken into consideration. . . . This, in our opinion, is based upon sound legal reasoning and is now announced as the rule to be followed in Pennsylvania.[3]

The court in the *Gradel* case, however, said:

> Most jurors would know from their own experience that ordinary income is taxable [but a charge to the jury] . . . would tell them that an award of damages is not taxable, something they are not otherwise likely to have known, but that the jury should not add or subtract taxes either to the calculation of lost earnings or to its award.[4]

Recognizing that the trial court properly left it to the jury to decide whether the defendant had been guilty of negligence, the Superior Court then went on to consider whether the defendant's negligence caused the amputation. Plaintiff's expert had testified that an earlier discovery of the tumor mass would have made it much more likely to have been removed, thereby avoiding the need for amputation. He, however, did not say with certainty that the earlier use of x-rays would have discovered the cancer before it had invaded the bone nor that an earlier discovery would have avoided a recurrence leading to amputation.

Relying heavily on its change of position in the two reported cases of *Hamil v. Bashline,*[5] the Superior Court stated:

> The trial court's direction to the jury, based as it is on the reasoning of *Hamil I,* was erroneous in permitting the jury to find the appellant's negligence responsible for the amputation simply because delay in taking an x-ray had increased the risk. More than that, the charge of the trial court incorrectly shifted the burden of proof to the appellant by sanctioning a verdict for the appellees unless the appellant affirmatively proved that the amputation would have been required in any event.[6]

Although the *Hamil II* case is currently before the Pennsylvania Supreme Court, the case of *Gradel v. Inouye* should give comfort to physicians weighted down by the burden of prospective medical malpractice law suits.

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[1] *381 A.2d 975 (Pa. Super. 1977).*
[2] *410 Pa. 530, 190 A.2d 293 (1963).*
[3] Id. *at 538, 190 A2d at 298.*
[4] Gradel v. Inouye, supra *at 985.*
[5] Hamil v. Bashline (Hamil I), *224 Pa. Super. 407, 307 A.2d 57 (1973), and* Hamil v. Bashline (Hamil II), *243 Pa. Super. 227, 364 A.2d 1366 (1976).*
[6] Gradel v. Inouye, *supra at 982.*

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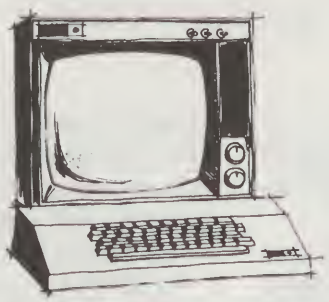
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editorials

Purge these words: 'accidentally poisoned'

It has been estimated that at least 2,000,000 childhood poisonings occur in the United States each year. Poisoning is most often named as the leading cause of recorded accidents in children under age five. The Pennsylvania Department of Health reports an overall annual incidence of product-related accidents at 77 per 1000 population. In children under five an annual rate of 127 per 1000 was reported. Poisoning is most frequently due to ingestion of medicine or other toxic substances in the home.

The most unfortunate aspect of accidental poisoning by ingestion is that it can be prevented. Many studies have observed that poisoning in the one-to-five age group tends to follow developmental patterns. In the very young, poisoning is most often due to iatrogenic error. At the crawling stage, ingested substances are usually those that can be reached by pulling up to low tables or shelves. As the child begins to walk, toxic substances in the immediate environment, such as laundry products and chemical cleaning agents, are responsible. Until ages three or four, the child explores the environment by taste; by four or five he tends to ingest substances that taste good, e.g., baby aspirin or cough medicine. Prevention of poisoning in these age groups requires total protection of toddlers and small children and early education of older children.

The principal chemical hazard in the home is improperly stored medicine. While it is true that common household substances are potentially hazardous, small amounts of most medicines can have catastrophic results. Several preventive measures are suggested by this fact.

1. All medicine should be put away. The Pennsylvania Department of Health summary of "Undesirable or Adverse Features of Products" reveals that accidental ingestion occurred due to the opening of "childproof" or safety caps or as a result of the product being left within easy reach, e.g., windowsill, bookcase, table top, or room divider.

2. All prescription medicine should be in childproof packages and should not be opened in front of children. Even though safety caps slow down the opening process, they are not foolproof and may be opened by accident or imitation.

3. All old or unused medicine should be disposed of. This simply narrows the chance of accidental discovery and ingestion.

4. All medicines should be kept in the original container for easy identification in case of acoident. Prompt identification of the agent may be necessary before initiation of treatment.

5. Cleaning agents, laundry products, pesticides, and other chemicals commonly used in the home should be kept in the original containers with safety caps in place. Toxic substances should be stored out of sight and out of reach. If possible, while there are young children at home these items should be under lock and key.

6. Finally, small children should not be left unattended for long periods while at play.

Because of the enormity of this problem, the physician should educate parents in the prevention of childhood ingestions. Should an accident occur, parents should be advised of the importance of emetics, how to use them, and what to expect when used. The number of the nearest poison control center should be available to every family whether or not they have young children.

Although the incidence of poisoning decreases markedly in older age groups, poison information centers provide an invaluable adjunct in the treatment of drug toxicity and overdose as well as in the management of household accidents. There are more than 600 poison information centers in the United States, 74 of which are located in Pennsylvania.

"It is better to avert a malady with care than to use a physic after it has appeared."—Shao Tze

David A. Smith, M.D.
Medical Editor

You are invited to attend

The thirty-first annual State Dinner

Wednesday, October 31, 1978—Host Farm Resort Motel, Lancaster

Reception — 7 p.m. Dinner, dancing, and entertainment — 8 p.m.

Installation of John B. Lovette, M.D., 129th president.

Presentation of past presidents' medallion to John V. Blady, M.D., 128th president.

Presentation of retiring trustee award to George A. Rowland, M.D., chairman of the Board of Trustees.

The Host Farm Resort Motel operates under the American Plan—breakfast and dinner are included in the room charge. Therefore, house guests will receive Reception/State Dinner tickets subject only to a $10 surcharge per person. The surcharge is a result of the menu selected for the Reception/State Dinner and will be added to the room charges. Tickets for those not registered at the Motel will be $18 per person. Both registered and non-registered persons may pick up their Reception/State Dinner tickets during the annual session at the Society's registration desk, which will be located in the Host Farm lobby.

MDs in the news



Centenarians have been honored with a State Society plaque since 1948. Celebrating her 100th birthday with Mrs. Lulu Gleckner of Canton are (l. to r.) Stanley Conklin, M.D., Sayre; Joseph Cady, M.D., Athens; and Orlo G. McCoy, M.D., Canton.

Evangelos T. Angelakos, M.D., Ph.D., Philadelphia, and **Elliott L. Mancall, M.D.,** Miquon, recently were elected to the board of trustees of Hahnemann Medical College and Hospital. Dr. Angelakos, who will serve as secretary of the board, is professor and chairman of physiology and biophysics at Hahnemann. Dr. Mancall is professor and chairman of neurology and president of Hahnemann's hospital medical staff.

Ralph W. Lorry, M.D., Philadelphia, was honored recently by Frankford Hospital for his 50 years of service to the 75-year-old hospital.

Thomas B. Souders, M.D., West Reading ophthalmologist, has been appointed editor of *Transactions,* the official journal of the Pennsylvania Academy of Ophthalmology and Otolaryngology. Dr. Souders has practiced ophthalmology at Reading Hospital since 1972.

Diran O. Mikaelian, M.D., Philadelphia, recently was honored for excellence in basic research by the Triological Society with its highest award, the Edmund Prince Fowler Award. Dr. Mikaelian is professor and acting chairman of otolaryngology at Jefferson Medical College.

Spencer Borden, M.D., Philadelphia, has been named radiologist-in-chief at Children's Hospital of Philadelphia and clinical associate professor of radiology at the University of Pennsylvania School of Medicine. He most recently was chief of pediatric radiology at Massachusetts General Hospital and assistant professor of radiology at Harvard Medical School.

Stanley W. Stanulonis, M.D., of Shenandoah, was honored recently as the Shenandoah Chamber of Commerce's "Man of the Year." Dr. Stanulonis has practiced internal medicine in Shenandoah for more than 40 years.

Six physicians were named recently to the medical and dental staff of Polyclinic Medical Center, Harrisburg. They are: **Peter M. Brier, M.D., Michael L. Gluck, M.D.,** and **Louis F. Kuskin, M.D.,** assistants in the division of internal medicine, department of medicine; **Bennett Chotiner, M.D.,** assistant in the department of surgery's division of ophthalmology; **Phillip H. Meyers, M.D.,** assistant in the division of oral surgery; and **Arnold T. Shienvold, M.D.,** assistant in the allied health field, department of family medicine.

William S. Carter, Jr., M.D., Abington, physician-in-chief of the psychiatric service at Abington Memorial Hospital and medical director of its mental health center, has been appointed clinical associate professor of psychiatry and allied health sciences at Hahnemann Medical College.

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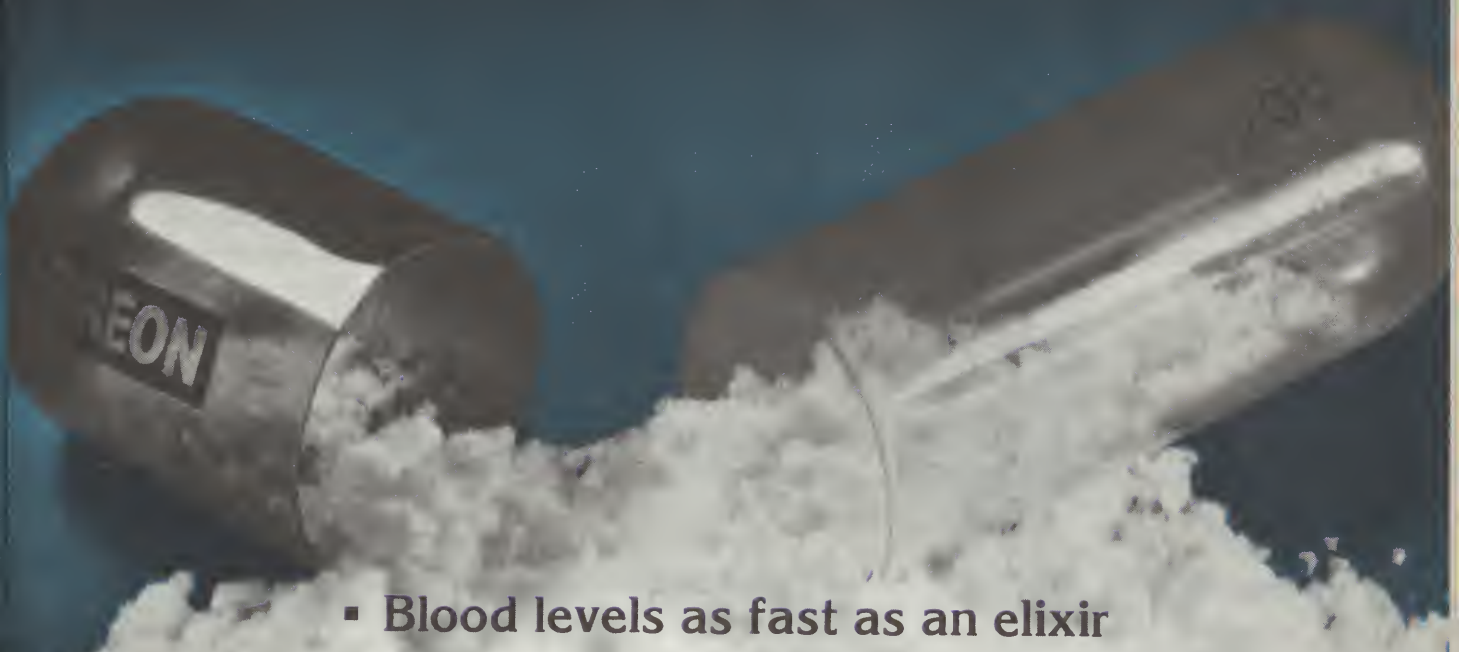
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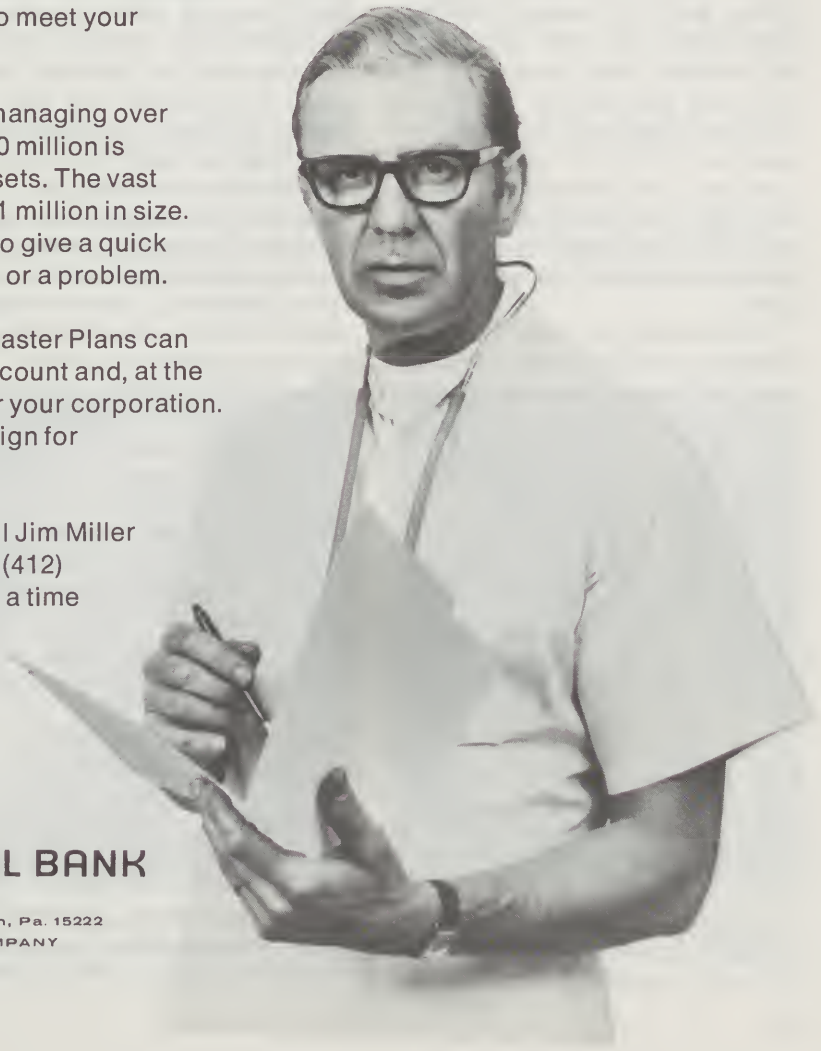
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Report of cases

Advances in vascular disease diagnostic techniques

Cherie M. Tobias, B.S.
Gary G. Nicholas, M.D.
John A. Waldhausen, M.D., F.A.C.S.

The clinical vascular laboratory at the Milton S. Hershey Medical Center, Hershey, Pennsylvania, was established in 1975. During that year, 300 patients were evaluated and monitored for vascular disease. In 1976 the laboratory performed approximately 35 tests per month on inpatients and outpatients. The facility employs noninvasive instrumentation, namely, Doppler ultrasound and segmental plethysmography.

The laboratory's primary function is evaluating patients with suspected vascular disease. It also aids in selecting patients for surgery and in evaluating the vascular reconstruction performed, and contributes to long-term follow-up studies of patients with vascular disease by evaluating the progression of underlying disease or the development of collateral circulation.[1]

Diagnostic procedures include evaluation of arterial hemodynamics in the upper and lower extremities, compression syndromes, vasospastic disease, and deep venous thrombosis. Evaluations are conducted at rest or after stress with treadmill walking, cold exposure, or positional alterations. Examinations are also valuable in diagnosing rest pain and in predicting healing of foot lesions and below-the-knee amputations.

Dr. Nicholas is associate professor and Dr. Waldhausen is professor and chairman of surgery at The Pennsylvania State University College of Medicine in Hershey. Ms. Tobias was vascular laboratory technician and research assistant at the time this paper was written.

For each evaluation by the clinical vascular laboratory, a consultation report containing data and the examiner's comments is placed in the patient's chart. A copy of the report is sent to the referring physician.

The highly sensitive quantitative segmental plethysmograph is designed for clinical use. The instrument produces a recording of the instantaneous pulsatile volume changes in the limb due to the passage of arterial pressure pulses. The resulting pulse volume is nearly proportional to the arterial pressure wave form.[2] The pulse volume contour and amplitude provide the key diagnostic information.

The Pulse Volume Recorder (Life Sciences, Inc., Greenwich, CT) can also be used to determine systolic and diastolic pressures in the various limb segments and digits. It is: (1) simple, reliable, and reproducible; (2) capable of standardization; (3) easily employed by paramedical personnel; (4) adaptable to measurements taken before and after exercise; and (5) able to produce a hard copy for reference.[3]

The vascular laboratory examination is no substitute for a good history and physical examination but rather an additional parameter to complement the clinical analysis.

Arterial disease

A routine evaluation of arterial hemodynamics in the upper and lower extremities consists of the following sequence:

1. For each visit, patient information and a brief vascular history including the existing clinical symptoms are reported
2. Peripheral pulses are palpated; bruits in the carotid, aortic, and femoral areas are documented; the presence or absence of Doppler signals in the feet is noted; and brachial blood pressures are determined
3. Segmental pulse volumes are recorded at the thighs, calves, and ankles of both lower extremities using standard blood pressure cuffs
4. Using either the Doppler blood velocity detection or the segmental plethysmography technique, thigh, calf, and ankle systolic pressure measurements are determined
5. Following these studies, measured exercise testing is performed

when indicated. The standard exercise is performed on a treadmill at a 10 percent incline and at a rate of either 1.5 or 2.25 mph. During the exercise period, onset, location, and severity of symptoms are reported. Immediately following the stress test, PVR tracings and systolic and brachial pressures are measured bilaterally at the ankle level. The exercise testing is useful in differentiating symptoms caused by vascular insufficiency and by neurologic or orthopedic disorders.[4]

Venous disease

The clinical diagnosis of deep venous thrombosis is notoriously inaccurate. The clinical vascular laboratory uses noninvasive techniques to determine the maximum rate of venous outflow from the extremity. The outflow rate has been shown to be an early and sensitive indication of deep venous thrombosis.

The venous return in the limb is momentarily obstructed by an occluding blood pressure cuff inflated to a value less than the diastolic pressure. As the blood pools in the veins distal to the cuff, the limb volume increases, causing a gradual rise in the monitoring cuff pressure. When the occluding cuff is released, limb volume rapidly decreases. In the presence of hemodynamically significant deep venous occlusions, the resistance to the flow increases and a decreased venous outflow rate results.

Noninvasive Doppler venous signals also are instrumental in detecting deep venous thrombosis. Although these techniques fail to detect small clots which do not increase venous resistance, they are valuable in screening patients with deep venous occlusions.

Case examples

Case 1. Common iliac occlusion. A 62-year-old man was admitted to the Hershey Medical Center with rest pain and gangrene in the great toe on his left leg. The constant pain in his left foot had been present for one month. During the preceding year he had noted intermittent claudication. He had no pulses palpable at any level in his left lower extremity.

The arterial pulse volume record-

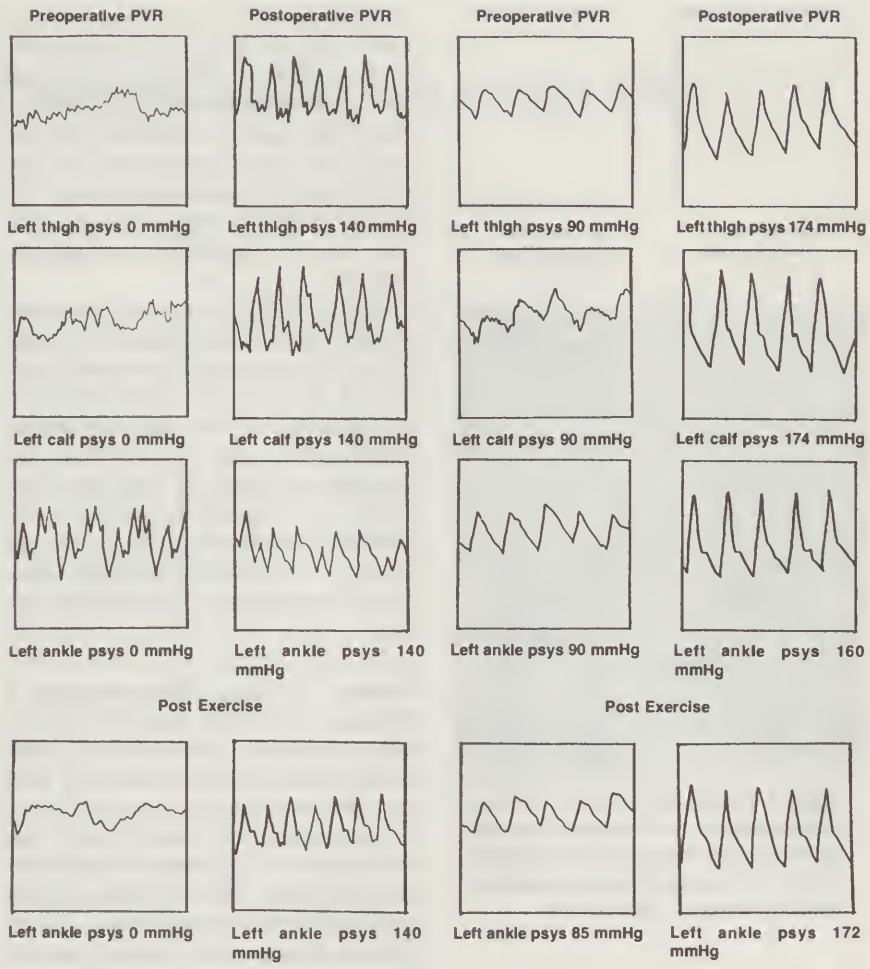


Figure 1. **Preoperative and postoperative pulse volume recordings from Patient 1 with left common iliac artery occlusion.**

Figure 3. **Preoperative and postoperative pulse volume recordings from Patient 2 with stenosis of both iliac arteries.**



Figure 2. **Angiographic findings from Patient 1 with left common iliac artery occlusion.**



Figure 4. **Arteriographic findings from Patient 2 with bilateral stenosis of the common iliac arteries.**

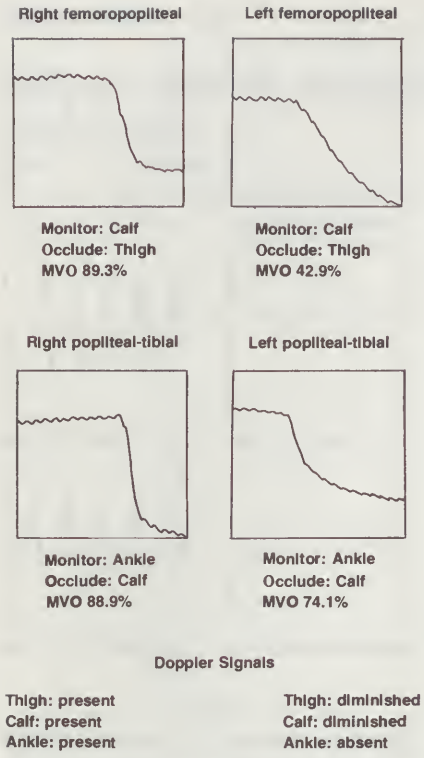


Figure 5. **Peripheral venous evaluation from Patient 3 with deep venous thrombosis of the left femoropopliteal system. Maximum venous outflow (MVO) normally > 50 percent.**



Figure 6. **Venographic findings from Patient 3 with deep venous thrombosis in the left femoropopliteal system.**

ings obtained showed a diminution in pulse amplitude as well as abnormal contour (Fig. 1). Exercise stress test was performed and revealed flattening of the pulse amplitude at the left ankle. The opposite extremity demonstrated normal exercise response. The diagnosis of left common iliac occlusion was confirmed by angiography (Fig. 2).

A common iliac and common femoral endarterectomy with insertion of a dacron graft was performed on the patient. He regained pedal pulses in the left foot, the area of gangrene separated, and spontaneous healing occurred. A postoperative evaluation (Fig. 1) showed increased pulse amplitude, normal systolic pressures, nearly normal contour, and a normal response to the exercise testing.

Case 2. Bilateral iliac stenosis. A 52-year-old woman was admitted to the center with persistent pain and purple discoloration of her left fifth toe. She had a past history of an elevated serum cholesterol and was being treated by dietary management and Clofibrate. Her left femoral pulse was diminished to palpation and no pulses were palpable distal to this level on the left. All distal pulses were present on the right side.

A preoperative evaluation at rest and after treadmill exercise (Fig. 3) demonstrated a slightly decreased wave amplitude, abnormal pulse contours, and reduced segmental systolic pressures at all levels on the left. Arteriography confirmed these findings by revealing stenosis of both iliac arteries with patent distal vessels bilaterally (Fig. 4).

The patient underwent insertion of a dacron aortic bifurcation graft. Following surgery she regained pedal pulses in the left foot. A repeat pulse volume recording (Fig. 3) prior to her discharge showed increased pulse amplitude, normal wave contour, and normal systolic pressures at rest and following exercise.

The examination not only confirmed the clinical findings but also objectively evaluated the vascular reconstruction.

Case 3. Deep venous thrombosis. A 67-year-old woman was admitted to the center with the chief complaint of sudden onset of left leg swelling. This swelling was first noted 12 hours prior to hospital admission. The entire left lower extremity was grossly swollen and slightly cyanotic in color. The posterior tibial and dorsalis pedis pulses were present bilaterally.

Doppler augmented venous sounds were diminished; maximum venous outflow was 43 percent in the left femoropopliteal system (Fig. 5). The clinical diagnosis of deep venous thrombosis was confirmed by venography (Fig. 6). In contrast, the presence of augmented Doppler ultrasound and maximum venous outflow greater than 50 percent in the right extremity are typical of a patent deep system (Fig. 5).

Vascular compression problems

The vascular laboratory also can be valuable in evaluating vascular compression problems. In the case of thoracic outlet syndrome, the plethysmographic recording is taken with the upper extremity in a series of positions. A damping of the arterial wave form is indicative of subclavian artery compression.

Digital small vessel occlusive disease and vasospastic disease can also be evaluated. Digital perfusion testing is valuable in evaluating the effectiveness of sympathectomy and vasodilators and in predicting the healing of ischemic lesions.

Conclusion

The clinical vascular laboratory is useful in the diagnosis and management of peripheral vascular disease. Its noninvasive techniques provide quantitation of vascular insufficiency and aid in the differential diagnosis of extremity symptoms. □

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Case report

Congenital absence of gallbladder and cystic duct

Victor C. Dy, M.D.
Lee S. Serfas, M.D.
Salvatore E. Cavallaro, M.D.

Cholecystectomy is one of the most common operations performed in the United States. Operating surgeons who are familiar with anatomy should be aware continually of the possibility of variation. Comparative anatomy on anomalous bile ducts in man has been well discussed by Mentzer.[1] In 1950, congenital absence of the gallbladder ranked fourth in rarity of biliary tract anomalies.[2] This anomaly was known to Aristotle (384-322 B.C.); the first pathological report was done by Lemery le fils (A.D. 1701).[3]

The condition is usually diagnosed during surgery or at autopsy, and incidence ranges from 0.01 to 0.075 percent. At Easton Hospital from 1962 through 1976, 2,729 cholecystectomies were done; only two examples of congenital anomalies of the gallbladder were found. In the first case, involving intra-hepatic gallbladder, diagnosis was not made preoperatively. The second case is presented. About 50 percent of patients with absence of the gallbladder were found at operation to have associated common bile duct stones.[4] More than 50 percent of cases were found at autopsy.[5]

Case report

A 34-year-old white male was admitted because of abdominal pain of two months' duration. The pain was episodic in the epigastrium and the right upper quadrant. He had no history of nausea, vomiting, jaundice, or fatty food intolerance. He had intermittently been taking antacid for duodenal ulcer which was diagnosed two years prior to admission. Upper GI and GB series done a week prior to admission revealed a normal UGI tract and nonvisualization of the gallbladder. The patient consulted the emergency room because of an increase in pain and subsequently was admitted. Past history was unremarkable. He had had an appendectomy at age 10.

Physical examination on admission revealed vital signs which were within normal limits. The patient was not jaundiced clinically. His abdomen was soft and mildly tender in the right upper quadrant. No masses were felt. The patient's test results were as follows: hemoglobin 15.5; hematocrit 44.1; WBC 12,800; Seg 86 percent; monocytes 2 percent; lymphocytes 11 percent; Eos 1 percent; total bilirubin 2.0 mg percent; alkaline phosphatase 90; amylase 95; urinalysis 10-15 RBC, 1-3 WBC; repeat 18-20 RBC, 1-3 WBC.

The patient was kept NPO and given intravenous fluids. Gastroscopy performed the day after admission revealed bile reflux gastritis. No evidence of ulcer was noted. A repeat gallbladder series was done with orografin reinforcement, and again the gallbladder was not visualized. An IVP done because of microscopic hematuria was essentially normal. The patient was subsequently scheduled for surgery with a preoperative diagnosis of nonfunctioning gallbladder.

The abdomen was entered through a right subcostal incision, and a gallbladder was not found. The liver appeared normal. No indentation at the inferior surface of the liver was found, and thus the possibility of intra-hepatic gallbladder was excluded. A few adhesions from previous appendectomy were encountered in the right lower abdomen. The remainder of the abdomen was normal, and no evidence of an ectopic gallbladder was found.



Figure 1. Operative cholangiogram with 25-gauge spinal needle visualizes biliary system and dye in duodenum.

The common bile duct was identified and appeared normal on inspection and palpation. An operative cholangiogram was done with a #25 gauge spinal needle and injection of 5 cc of 25 percent hypaque. The ductal system was well visualized with free flow of dye into the duodenum (Figure 1). No stones were noted.

The gallbladder and cystic duct were absent. There was no intrahepatic gallbladder. The common bile duct was not explored. A Penrose drain was inserted and the operation terminated.

The post-operative course was essentially uneventful. On the third post-operative day the Penrose drain was removed. A repeat urinalysis at that time revealed no hematuria. Repeat total bilirubin yielded 1.0 mg percent. The patient was given Questran (cholestyramine) for bile reflux gastritis with improvement of symptoms. He was discharged on the sixth post-operative day.

We attributed the symptoms to gas-

Dr. Dy, formerly chief surgical resident at Easton Hospital, is a pediatric surgeon at Memorial Sloan-Kettering Medical Center, New York. Dr. Serfas is director of surgery and Dr. Cavallaro is attending surgeon (retired) at Easton Hospital.

tritis. We were not able to explain the transient hematuria or the single elevated bilirubin on admission. The patient has remained asymptomatic since surgery.

Discussion

Dixon and Lichtman have postulated two theories for the congenital absence of gallbladder.[6] First, the anomaly is due to failure of the gallbladder bud to develop from the hepatic diverticulum. This failure also results in the absence of the cystic duct. Second, the anomaly is due to failure of the gallbladder bud to resolve from its solid stage; hence, in such a case, a remnant of cystic duct is present.

Kobacher[7] in 1950 suggested the possibility of hereditary defect. His findings were supported by Nadeau *et al.*[8] who found 12 cases in the same family. Bartone and Grieco[9] in 1970 brought out the possibility of absence of gallbladder secondary to severe inflammatory disease which destroys the organ. This should not be classified as agenesis of the gallbladder.

Literature on the topic has been reviewed by several authors. Frey *et al.*[10] have suggested two criteria for accurate diagnosis: (1) accurate dissection of the hepatoduodenal ligament and biliary ductal system from the bifurcation of the hepatic ducts to the duodenum, gallbladder fossa, and hepatic area and an accurate description of the findings in the case report; and (2) operative cholangiogram or postoperative T-tube cholangiogram to rule out intra-hepatic gallbladder. Langley and Hull[11] reviewed the literature in 1974 and claimed there are less than 300 reported cases. When Frey's criteria are strictly followed, there are even fewer cases.

Congenital absence of gallbladder with choledocholithiasis could account for the clinical presentation; such cases have been reported.[12,13] Stones could also be present in the hepatic duct. If choledocholithiasis is suspected, or obvious clinically or by operative cholangiogram, the common bile duct should be explored and a T-tube inserted. In our case, the common bile duct appeared normal and needle cholangiogram showed free flow of contrast material to the duodenum. We thus saw no indication to explore the common duct, particularly with the additional morbidity and mortality this procedure causes.

Between 40 and 67 percent of patients with congenital absence of gallbladder have other associated anomalies.[14,15,16] The explanation is unclear. The most frequently reported associated anomalies are ventricular and atrial septal defects, pulmonic stenosis, imperforate anus, and recto-vaginal fistula. Absence of the corpus callosum with microcephaly; atresia of external auditory canals; tricuspid atresia; tracheo-esophageal fistula; dextroposition of the pancreas and esophagus; absent spleen; high position of the cecum; cystic kidney; horseshoe kidney; rudimentary thumb; and hypoplastic scapula and radius are less frequently reported associated anomalies.

Pre-operative diagnosis of absence of the gallbladder remains a challenge to the surgeon and, from a practical standpoint, is essentially impossible. Reported cases have been diagnosed during laparotomy or at autopsy except that reported by Gupta in which the diagnosis was suspected preoperatively.

It is important to rule out an abnormal location of the gallbladder. Abnormal locations which have been reported are: intra-hepatic, leftsided gallbladder; transverse gallbladder; gallbladder within the falciform ligament; floating gallbladder; retrodisplacement of the gallbladder; subcutaneous gallbladder; and suprahepatic gallbladder.[17]

A diagnosis of intra-hepatic gallbladder may be made by liver scanning.[18] The normal or abnormal location of a nonfunctioning gallbladder may be demonstrated with ultrasound (echogram). It is impractical to subject all patients with a "nonvisualized gallbladder" to liver scan or echogram studies because of the expense and the low incidence of anomalies. In selected patients with "nonvisualized gallbladder" who have other congenital anomalies or a family history of biliary tract anomalies, liver scan and/or echogram may be indicated to rule out congenital anomalies if oral cholecystograms and IV cholangiograms are inconclusive. We know of no such report in the literature.

Conclusion

Absence of the gallbladder may represent: true congenital absence; "absence" because of a contracted obliterated gallbladder that is not readily demonstrable even at the time of surgery; or an "absent" gallbladder that is present in an ectopic position not appreciated by the surgeon. Accurate differentiation must be made at surgery to ensure appropriate treatment.

In cases of agenesis, associated congenital anomalies should be suspected.

Pre-operative diagnosis remains difficult, if not impossible. With scanning and echogram, the diagnosis, if suspected, may be made preoperatively.

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DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy,* Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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Communication deterrent to suits

A programmed course in human relations

Kenneth Lohr
Nancy Maddock Long

The literature and press about malpractice often overlook one fundamental element—the human factor. Incompetence aside, how can your patient carry out a lawsuit against you when he knows you care about him personally? How can he press charges against you when you communicated openly with him throughout consultation and treatment? Such action counters human relations psychology.

Human relations demands free communication between you and your patients. Your first steps toward this goal are perceiving and observing your patients as total, unique individuals. The following vignette illustrates the importance of these measures in the doctor-patient relationship.

Dr. Robinson slumps back in his chair and glances involuntarily at the clock. Five minutes ago it was 2:25; now it is 2:30. The pile of papers on his desk still contains five folders. Calculating every minute, he figures he will have to hurry his appointments to be on time for dinner with his wife. This thought reminds him of the terrible morning he had. First he couldn't find the car keys, then she gave him the third degree because he was so uptight. No wonder he has such an annoying headache. Rubbing his tense neck muscles, he reaches for some capsules. Two weeks ago he would not have reacted this way to a headache. But last week he learned of the impending malpractice suit and now he takes the medication automatically.

Prepared to get down to business, he directs his secretary to admit the next patient—a Miss Thomas according to the folder. Whatever her problem, he hopes it won't take too long. Miss Thomas, he assumes, appears at the door. She is a blonde, good-looking woman. Dr. Robinson adjusts his tie and rises.

The patient lingers in the doorway and looks around the room. She studies everything as if fixing the space in her mind before venturing any further. For an instant her glance falls on him and their eyes meet but before she sees his best smile, she returns to examining the office. Two chairs furnish the room—one about four feet in front of his desk and the other about six feet to the side. Finally, she crosses the threshold and strides to the farther chair.

The doctor observes that the woman not only has good looks, she has good taste too. She is fashionably and expensively dressed. He feels certain of her acceptance at any of his wife's social functions. Once again, he mentally notes to speed things up so he won't be late for dinner. The patient's shoulder sling purse catches his eye and he watches as she sits carefully in the chair and crosses her legs.

He clears his throat. Her eyes quickly dart in his direction and just as quickly dart away. In his most professional manner he introduces himself. She responds by confirming that she is Miss Thomas. Her soft voice surprises Dr. Robinson; for some reason he was expecting something louder. Miss Thomas clutches the book she brought with her as Dr. Robinson asks how he can help.

She reluctantly begins, "I just haven't been feeling well lately." Her voice falters but he encourages her to continue. She crosses her legs again and strokes the clasp of her purse. She proceeds with her story interjecting many "uhs" and "ers." Whenever she thinks she's misleading or displeasing Dr. Robinson, she says "I'm sorry" or starts over again. Every time he recognizes possible clues he stops her and asks her to elaborate.

"Recurring headaches" keeps popping into the conversation. He certainly sympathizes with this problem. He leans back in his chair and crosses his arms behind his head. Miss Thomas relaxes in hers. He asks if she'd mind his smoking. For the first time she smiles convincingly. She confesses that she is dying for a cigarette but was afraid to ask "what with doctors and lung cancer and all." She giggles and he laughs with her. "At least you're human," she exclaims. Dr. Robinson looks at her in surprise.

She tells him she's an executive in a predominantly male organization. She constantly taps her ash on the tray he gave her. Her voice rises. Dr. Robinson remembers his wife's diatribes on women's lib. She and Miss Thomas might get along but, then again, maybe not. Leaning forward, he looks at Miss Thomas with interest.

Miss Thomas says she's competing with two men for a promotion. Her headaches interfere with her concentration on the job and are hindering her chances. Her voice fades and he leans closer and smiles encouragingly. She moves her chair toward the desk and brushes the hair out of her eyes.

Dr. Robinson likes Miss Thomas. She seems to sense his interest and her words begin to tumble forth. Her hands punctuate her story in excited motions. Sometimes she peers at him and asks "you see" or "you understand?" When she stops to light another cigarette, he asks about her medical history. He thinks he's ready to prescribe a treatment. But Miss Thomas asks her own apparently unrelated questions after his. Suddenly she blurts out a symptom indicating a far more dangerous condition than severe headaches. Dr. Robinson immediately rejects the diagnosis he was contemplating. Gently he tells her not to be afraid, but to go on with her story. She sighs, unclasps her hands, and proceeds in a matter-of-fact voice.

During the remaining time of the consultation the two discuss possible causes, treatments, and outcomes. As they finish, Miss Thomas stands and

Authors Lohr and Maddock are behavioral scientists specializing in human relations and communications problems. Their office is in Camp Hill.

extends her hand. Dr. Robinson walks around his desk, shakes her hand, and places his left hand on her arm. Miss Thomas leaves the office smiling.

Dr. Robinson realizes he spent more than the allotted time with this patient. He will be late for dinner but he feels it was worth it—at least he and Miss Thomas communicated freely with each other. He regretfully wishes he had done the same with another patient.

Program instructions

This scene is packed with more than one hundred identifying behavioral signals. Each, knowingly or unknowingly, indicated the constantly changing personality states of the doctor and the patient.

The following program is designed to teach you how to observe, identify, and interpret the verbal and nonverbal clues that every person sends every second of his life. People cannot prevent themselves from revealing personality and emotional clues. Trained to recognize and interpret these clues, you can control interpersonal situations and enhance communication and human relations with your patients.

The program is presented in frames, each of which contains information and frequently questions and answers. Keep the answers to each frame covered with a slip of paper until you have written your answer. Check your response with the correct answer in the margin.

The information in this programmed instruction can be used in a variety of interpersonal situations to improve human relations. Here are a few suggestions.

- Observe the patient's nonverbal behavior. His body movements, paralanguage, affect displays, and use of proxemics indicate his physical and emotional state.
- Let the patient describe himself in his own words without interruption. The interview should be more than just a series of questions and answers. The patient must feel special.
- Since the patient in unlikely to offer all the pertinent facts on his own, you must elicit the needed details.
- Allow the patient to start his story anywhere he wants. You choose the clinically important details and ask him to elaborate on them.
- Being silent while the patient is speaking indicates your interest. Don't fill in the blanks for him even when he is groping for his next words. When he becomes emotional, extend him the courtesy of remaining quiet.
- Get the patient to continue speaking through your own appropriate nonverbal behavior. Remain silent, appear interested, nod your head in understanding or interject an occasional "I see."
- Although the patient may be talking, what he is saying nonverbally with his body may be more revealing. Asking him about his posture or facial expression may help him communicate more about his problem.
- Encourage the patient; exhibit a sincere interest in what he is saying; and reassure him so that he can express even painful emotions.
- When the patient has not explained a situation adequately for your interpretation, you should ask direct questions in such a manner that the patient doesn't answer in a required way or merely to gain approval.
- Explaining relationships between the patient's symptoms and his emotional problems may help him understand his problem and follow the prescribed treatment.
- Interjecting your thoughts and conclusions early may influence the patient to present the rest of his story just to support your statements.
- You should present your conclusions to the patient in words he can understand, explain the uncertainties, the process and outcome of the treatment, and your own interest in his health and the ultimate result.

Be aware that whether true or not, a patient may harbor some of the following attitudes when he enters your office.

You are rich.
Doctors make mistakes all the time.
You must discover my problem.
Other doctors didn't help me.
Prescriptions cost too much.
I won't go into a hospital.
Are all those tests and x-rays necessary?
I had to wait too long to see you.
I only came because someone made me.
I'm not articulate.
You frighten me.
I want you to like me.
Taking medicine frightens me.
I'm afraid of what you might find out is wrong with me.
You are powerful.
Your nurse is unpleasant.
I don't like the way you look.

This programmed instruction was designed to show you how, by improving your observation and listening skills, you can help your patient communicate with you. You will be rewarded by having more confidence in your diagnoses, and your patient will have more confidence in you. He will not withhold information or be afraid to ask questions about the possible outcomes of his treatment. He will be likely to follow your advice and to like you as a person. □

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behave

1. Behavior is always occurring and always visible. Even when a patient is not talking and is sitting perfectly still he is behaving. It is impossible not to behave.
A patient may decide not to talk, but he can't decide not to _____.

communicate

2. *Communication* is interaction between two or more people that conveys a message.
When you get angry you usually _____.

observant, aware

3. Whether or not we fully understand the message the other person is communicating depends on how well we observe verbal and nonverbal behavior.
Being more alert and _____ of a patient's behavior will help you understand what he says.

doing, communicating, revealing

4. Awareness is sensitivity to nonverbal clues. People vary in their levels of awareness. Most people view the nonverbal activity of others as more significant than their own nonverbal activity.
Most of us are aware of what we are saying, but we are not aware of what we are _____ with our faces and bodies when we say it.

5. Being more alert to your own body movements and facial expressions will make you more aware of the nonverbal behavior of others.

deliberate

6. We tend to think of what we do as natural and what other people do as deliberate. When, during a consultation, your patient abruptly leaves you may feel that he disagrees with you. But when you leave it is because you are late for a prior appointment.
The movement is the same, but we view our own action as spontaeous and natural and the other person's action as intentional and _____.

behavior, actions

7. Often potentially important behavioral clues go unnoticed. By becoming more observant and increasing your level of awareness it is possible to improve your understanding of the behavioral messages being conveyed by other's verbal and nonverbal _____.

random

8. There are three kinds of nonverbal actions. The first are movements that are *random*. These are movements without underlying behavioral meaning, such as sneezing or eyeblinking.
A person who scratches an itch exhibits a _____ movement.

idiosyncratic

9. The second nonverbal action is *idiosyncratic*. These movements are mannerisms which a person performs regularly. Because these habits have been accumulated over a lifetime, they are potentially significant in communication.
Nodding one's head in agreement or tapping one's fingers on a table are examples of _____ movements.

shared

10. The third nonverbal action is interpersonal and is called *shared*. The significance of an individual's act may be shared by one or more people. Only you and your closest friend may know that you pull your ear when you are puzzled.
When the meaning and importance of an action are recognized by someone else, its significance is _____.

random
idiosyncratic
shared

11. Write whether the following actions are random, idiosyncratic, or shared.
sneezing _____
standing with hands in pockets _____
your colleague fusses with his tie and you have learned this means he is getting impatient _____

affect display

12. *Affect display* is the expression of emotions such as surprise, anger, and joy through nonverbal clues. This display may be consciously or unconsciously expressed.
A child who doesn't want to get a shot and hides behind his mother's chair is exhibiting an _____

face

13. Facial expression is the most important communicator of affect. The face is highly visible and is the key to personal recognition. A particular facial expression is a combination of a person's individual anatomy and his culturally learned patterns of behavior.
The most important communicator of affect is the _____.

know

14. The interpretation of a given affect display also depends on how well you know the person behaving. A stranger may judge your actions as random movements, but a close friend may recognize them as personal idiosyncrasies.
How you interpret your patients' actions depends on how well you _____ them.

interpret, understand

15. The more observant you are of your patients the better you will be able to remember and _____ their behavior.

16. Eight primary affective states have been identified by Tomkins and McCarter. They are usually easy to distinguish from a state of emotional neutrality.
    1. Interest-Excitement: eyebrows down, eyes track, look, listen
    2. Enjoyment-Joy: smile, lips widened up and out, smiling eyes

3. Surprise-Startle: eyebrows up, eyes blink
4. Distress-Anguish: cry, arched eyebrows, mouth down, tears, rhythmic sobbing
5. Fear-Terror: eyes frozen open, pale, cold, sweaty face, trembling, with hair erect
6. Shame-Humiliation: eyes down, head up
7. Contempt-Disgust: sneer, upper lip up
8. Anger-Rage: frown, clenched jaw, eyes narrowed, red face

There are many possible combinations of these eight basic emotions.

micro

17. Some facial expressions are so transient that the person is unaware of them. They are called *micro* expressions because they last only 1/5 to 1/8 second. A trained observer, however, can recognize them as attempts to conceal internal emotions.

    A person telling about a humiliating experience may think he has disguised the shame he felt, but the _____ expression of momentarily looking down would reveal his inner emotion.

short

18. Micro affect displays are facial expressions of very _____ duration.

affect, emotion

19. Facial expressions can occur very rapidly and are thus the primary means of displaying _____.

affect

20. Another type of nonverbal behavior is body movement. Body movements are a response to an affect. They do not directly display the emotion but are a consequence of it.

    When a person uses a body movement as a means of nonverbal behavior he is responding to an _____.

body movement

21. The type of nonverbal behavior that conveys the intensity of an emotion is _____ _____.

22. Facial expressions display affect, but body movements are a response to an affect.

head, face body

23. The head and the body transmit different kinds of information. The head and face convey the type of emotion (fear, pleasure). The body indicates the intensity of the affect.

    The kind of affect is displayed by the _____ and the strength of the emotion is conveyed by the _____.

face

24. There are three measurements of the sending capacity of a body part:
    1. Average transmission time
    2. Number of patterns which can be sent
    3. Visibility

    The face has short macro and even shorter micro expressions, is capable of a variety of muscle positions, and is highly visible. The feet and legs move slowly, have limited movements, and are not very visible.

    The part of the body with the greatest sending capacity is the _____.

less
more

25. Because hand movements take time to perform, can have a wide variety of positions, but can easily be concealed, you would expect the sending capacity of the hands to be _____ than that of the face but _____ than the legs and feet.

leakage

26. A person may try to conceal his nonverbal behavior. The term *leakage* refers to body movements and facial expressions which escape a person's control.

    When a patient tries to cover up an emotion the information that gets through is called _____.

micro

27. When a patient is trying to prevent leakage of his true feelings, he may be able to control his overall facial expression but not the _____ affect display.

leakage

28. Micro displays can result from attempts to disguise _____.

He wants you to find out

He feels guilty about lying to you

29. There are three reasons why leakage takes place.
    1. The patient does not really want to succeed in the deception.
    2. He may feel guilty about trying to cover up the emotion.
    3. The patient is unaware of the sigificance of the behavior or thinks you will not pay any attention to it, so he doesn't attempt to inhibit it.

    A patient has not taken his medication as directed, but assures you he always did so. He avoids direct eye contact in speaking with you. List two possible reasons for the leakage.

    _____

    _____

less

30. The rate of body movement increases with increasing stress.

    A relaxed patient will shift his position (more/less) _____ frequently than a tense patient.

31. An ability to interpret nonverbal behavior depends on past experience. The more a person is sensitive to his own feelings and emotions the better he is able to communicate nonverbally. In other words, we must be able to tune in to ourselves before we can tune in to others.

paralanguage

32. *Paralanguage* is another area of nonverbal behavior that conveys emotion. Paralanguage deals with how something is said, not what is said.

    Vocal rate, volume, and pitch are aspects of _____.

paralinguistic

33. The verbal function of speech is linguistic.
The nonverbal function of speech is _____.

emotions

34. The quality and tone of a person's voice are indicative of his emotion.
You can learn much about a patient's mood and _____ from listening to what he says and more importantly, how he says it.

voice

35. We are all victims of our voice. People have stereotyped conceptions of the relationship between particular vocal qualities and certain personality traits. A person with a flat, monotonous voice may be considered boring and dull while in fact he is merely a victim of this inherited vocal characteristic.
In observing nonverbal behavior do not base your assessment of others' personalities and moods on your own stereotyped conceptions of certain _____ characteristics.

emotional

36. Disruptions of speech and hesitations are important paralinguistic clues to emotion.
When a patient hesitates, repeats himself, stutters, or uses a lot of "ahs," he is telling you a great deal about his mood and _____ state.

voice

37. In addition to being an indicator of personality, the voice is an indicator of the state of human interaction. An angry or anxious voice sets up a different interaction than a friendly, calm voice, even when the verbal message is the same.
Establishing a positive state of interaction depends on using the appropriate tone of _____.

how or how much you leak

38. Your interaction and relationship with people depend not only on what you say, but on _____ you say it.

proxemics

39. Communication is regulated by physical interaction. Dr. Edward T. Hall coined the word *proxemics* to describe how we use the space around us. Dr. Hall defines proxemics as "the interrelated observations and theories of man's use of space as a specialized elaboration of culture" and as "the study of how man unconsciously structures microspace—the distance between men in conduct of daily transactions, the organization of space in his houses and buildings, and ultimately the layout of his towns."
How near or far we are from the person to whom we are talking is part of the science of _____.

distance

40. Proximity is the physical _____ between people engaged in interaction.

personal space

41. Every person has a natural sense of personal space which is a subjective awareness of the physical space around him.
A patient's ability to relate to you is related to his use of _____ _____.

public
intimate
social-consultive
personal

42. There are four zones of territory in which we interact:

1. Intimate distance	0-18″
2. Personal distance	1½-4′
3. Social-consultive distance	4-12′
4. Public distance	12-40′

comfortable, at ease, relaxed

43. People vary with regard to the distance at which they feel _____ with other people.

larger

44. People generally maintain a (larger/smaller) _____ zone of territory with strangers than with acquaintances.

distance

45. In communicating with people it is important to maintain the proper _____ called for by the situation.

belongs

46. Each person claims the space around him as his own. The size of this territory is influenced by the individual's personality and his cultural background.
Each patient feels that the space around him _____ to him.

violate

47. Space can be misused in human interaction. Someone who is unaware of or ignores another person's zone of territory may unintentionally violate it. This intrusion into the space the other person feels belongs to him can arouse feelings of tension and discomfort.
When you interact with a patient you must be aware of that extension of his ego he calls his own space so that you do not _____ it unwittingly.

space

48. People have a strong need for personal _____ and resist invasion of it.

stress, uneasiness

49. The physical interaction in the doctor-patient relationship necessitates occasionally invading your patient's space.
When you must professionally enter your patient's intimate zone (to listen to his heart, for example) you should be aware of the tension and _____ _____ this may arouse in him.

close

50. People regulate intrusions of their personal space with various types of nonverbal behavior. One way is varying the degree of eye contact. When a person is threatened by being too close to someone he tries to defend himself by reducing the amount of eye contact.
If a patient does not look directly at you when communicating, it may be because you are too _____ to him.

look

51. Sitting directly in front of a patient can be uncomfortable for him because he is forced to always _____ at you.

indicator

52. The most significant indicator of personal and social orientation is eye contact. It is a powerful form of nonverbal communication because our eyes are our means of observation. We all know the feeling of being examined.
Because of the reciprocal nature of eye contact, it is a significant _____ _____.

indicators

53. Because nonverbal behavior is continuous, observable, and not easily concealed, it serves as an INDICATOR of the state of interaction. Through nonverbal clues we indicate our evaluations, impressions, and feeling for others.
Eye contact, body orientations, and gestures are used as _____.

eye contact

54. The degree of eye contact varies during interaction and is dependent on several variables. One factor is the extent of the participants' familiarity with each other. As people become more involved with each other, the time spent in mutual eye contact increases.
One type of nonverbal communication that can be used to gauge the patient's involvement with you is _____ _____.

equilibrium

55. The frequency of eye contact increases to a point of equilibrium where a balance between approach and avoidance is achieved. When eye involvement exceeds the equilibrium point anxiety results. To reduce anxiety, eye contact is decreased to a more comfortable level. The approach-avoidance balance varies among individuals.
The point of _____ of eye contact between you and your patient will vary from patient to patient.

territory, distance

56. There is an interrelationship between the degree of eye contact and distance at which the interaction takes place. People at social distances spend more time in mutual eye contact than those at a personal distance.
Observing the frequency of eye contact with your patient will indicate the zone of _____ at which you are interacting.

increase

57. When the interviewer gives positive feedback mutual eye contact increases.
When you give a positive reaction to what a patient says, eye contact will probably (increase/decrease) _____.

eye contact, visual contact

58. Other factors influencing the pattern of visual contact are the perceived sincerity of the speaker, the participants' attitudes, and the patient's expectation of approval or recognition.
There are a variety of factors affecting the pattern of _____ _____ between doctor and patient.

personality emotional stability

59. Another personality factor influencing eye contact is emotional stability. People with emotional problems or guilt feelings generally look at you less.
Observing a patient's looking behavior will indicate something about his _____ _____ and _____.

dominant

60. There is a correlation between looking behavior and the relative power positions of the participants. How you look at a patient indicates to him the relative dominance-submission character of your relationship. Studies have shown that the person who perceives himself to be the less powerful will look more often at the powerful person.
If you look infrequently at a patient he may be strongly influenced and consider himself in the submissive role and you in the _____ role. This perceived power interaction can have a significant effect on the entire relationship.

dominant

61. The pattern of eye contact is related to whether a person considers himself to be _____ or submissive in a given interaction.

eye contact

62. Personal orientation is indicated by eye contact. Encounters begin with a mutual glance which signals your awareness of the other person and your interest in furthering the interaction.
The most important act of nonverbal behavior in establishing communication is the initial _____ _____.

interest

63. Even a slight interruption in the mutual looking during the onset of an interaction can indicate a loss of _____ in the other person.

avoid, break, lose

64. Eye contact may indicate interpersonal awareness, but looking behavior can also produce an avoidance tendency.
A person's unwillingness to be gazed at causes him to _____ eye contact.

avoid

65. A patient whose previous doctor displayed disapproving facial expressions may _____ looking at you for fear of getting the same reaction.

leakage

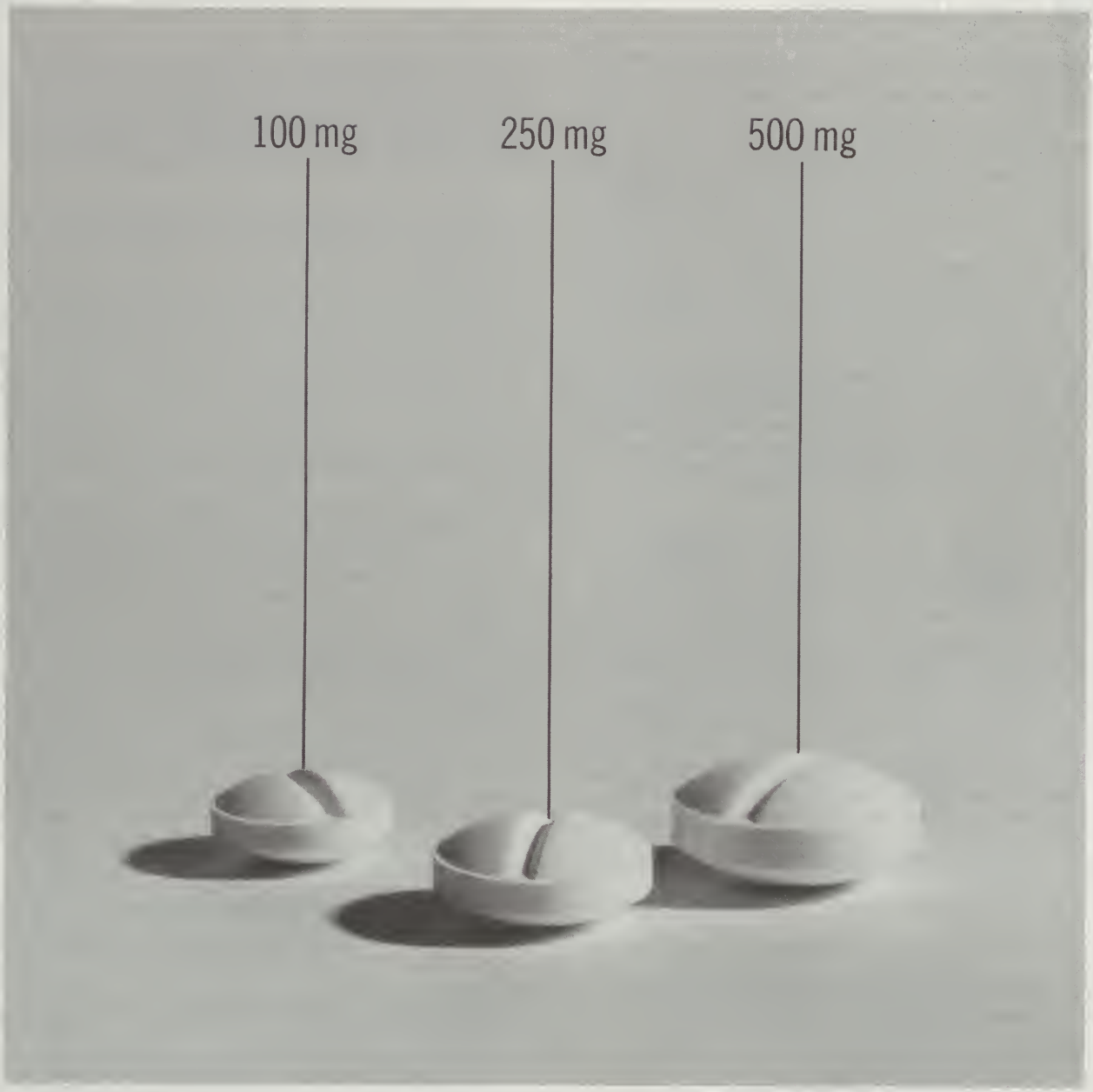
66. When a patient who is being stared at is trying to conceal his emotions, he may avoid eye contact in an effort to prevent _____.

thing, object

67. Another way to avoid someone is to look at him in a way that reduces him to a nonperson. Since staring is reserved for objects and things, when you stare at a person he becomes nonhuman in your eyes. Staring at a patient reduces him from a unique human being to just another _____.

look, stare

68. The most injurious avoidance aspects of eye contact are contemptuous, condescending, or discriminating looks.
The way in which you _____ at a patient may indicate your opinion of him or your attitude toward his behavior which could be detrimental to the interaction.



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NOVEMBER 1978

Eastern Pennsylvania Chapter of the
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Twenty-Seventh Annual Meeting

Holiday Inn (Poconos - Lake Harmony) off Route 940, ½ mile east of I-80 Exit 42 and Pennsylvania Turnpike Exit 35

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Robert N. Clark, M.D., Morgantown
Stanley D. Dudrick, M.D., Houston
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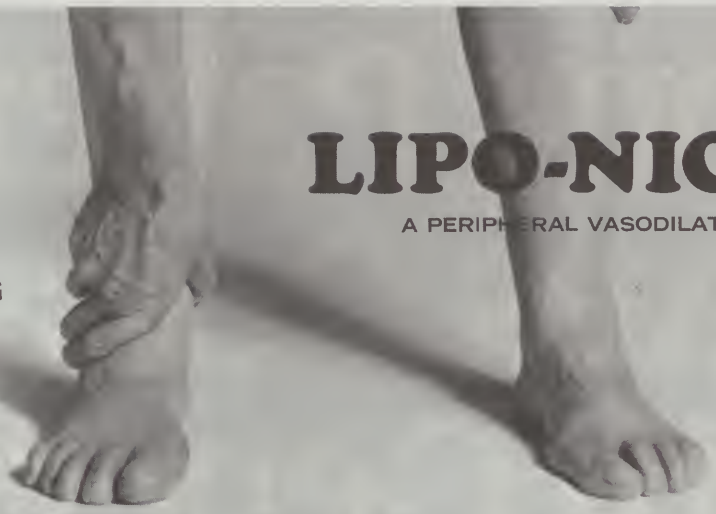
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obituaries

• Indicates membership in the Pennsylvania Society at time of death.

• **Simon Ball,** Philadelphia; Temple University School of Medicine, 1926; age 76; died May 2, 1978. He had served as team doctor for the Philadelphia Warriors and 76ers and had been chief of the ear, nose, and throat department at Einstein Medical Center's Northern Division and associate professor of otolaryngology at Hahnemann Medical College and the University of Pennsylvania School of Medicine.

• **Malcolm J. Borthwick,** Shavertown; Jefferson Medical College, 1933; age 71; died May 10, 1978.

• **Samuel Baron,** Philadelphia; Jefferson Medical College, 1917; age 85; died February 2, 1978.

• **Elvin J. Bateman,** Ligonier; Ohio State University College of Medicine, 1920; age 82; died April 12, 1978. He had practiced obstetrics and gynecology.

• **Joseph G. Buchert,** Philadelphia; Jefferson Medical College, 1936; age 67; died June 13, 1978. He was a general practitioner who had served as a flight surgeon during World War II.

• **John C. Burns,** Glenside; Temple University School of Medicine, 1925; age 77; died April 6, 1978. Dr. Burns had practiced medicine and surgery in Wyncote and Jenkintown until his retirement in 1973.

• **James F. Cipoletti, Jr.,** Washington; West Virginia University School of Medicine, 1971; age 34; died June 7, 1978. He had practiced internal medicine, specializing in rheumatology.

• **Joseph N. Grossman,** Philadelphia; Temple University School of Medicine, 1935; age 68; died February 27, 1978.

• **Elwyn L. Heller,** Rockwood; University of Pittsburgh School of Medicine, 1936; age 67; died April 15, 1978. He had served as associate professor of pathology at the University of Pittsburgh School of Medicine.

• **Andrew B. Hesz,** Sewickly; age 61; died June 18, 1978. He had been associate chief of staff for ambulatory care at the Veterans Administration Hospital, and had served on the staff for 18 years.

• **Ladd E. Hoover,** Doylestown; University of Nebraska College of Medicine, 1926; age 75; died December 26, 1977.

• **James B. Jamison II,** Beaver Falls; Jefferson Medical College, 1950; age 51; died April 9, 1978. Dr. Jamison had practiced urology in Beaver Falls for 20 years.

• **Rolf E. Johnson,** Nazareth; Duke University School of Medicine, 1940; age 63; died April 1, 1978. Dr. Johnson had practiced orthopedic surgery in Easton for 31 years.

• **Arthur L. Koven,** Hazleton; Louisiana State University School of Medicine, 1942; age 63; died May 21, 1978.

• **John H. Lapsley,** Indiana; Temple University School of Medicine, 1930; age 75; died March 21, 1978. Dr. Lapsley had been chairman of obstetrics at Indiana Hospital from 1957 to 1973 and had served as president of the hospital staff in 1947 and staff representative to the board of trustees in 1953.

• **John W. Larson,** Meadville; Temple University School of Medicine, 1944; age 60; died April 14, 1978. Dr. Larson served as medical director of the Erie County Department of Health at the time of his death.

• **William A. Lell,** Chestnut Hill Village; University of Rochester School of Medicine, 1931; age 76; died May 1, 1978. Dr. Lell had been chairman of broncho-esophagology and laryngeal surgery at Pennsylvania Hospital from 1940 to 1965 and had taught the subject at the University of Pennsylvania School of Medicine for 25 years.

• **Adam O. Malz,** Philadelphia; University of Lwow, Poland, 1939; age 63; died April 16, 1978. Dr. Malz had practiced obstetrics and gynecology in Philadelphia since 1969.

• **Stanley B. Morgenlander,** Pittsburgh; Long Island College of Medicine, 1944; age 57; died May 24, 1978.

• **Thomas V. Murray,** Sharon; Temple University School of Medicine, 1938; age 64; died May 11, 1978. Dr. Murray retired from private surgery practice in 1975, after which he assumed full duties as first medical director of Sharon General Hospital.

• **Edith E. Nicholls,** Gainesville, Florida; Yale University School of Medicine, 1926; age 81; died March 1978.

• **Albert A. Novak,** Astatula, Florida; Medico-Chi College of Philadelphia, 1915; age 86; died March 13, 1978. He had practiced family medicine in the Beaverdale area.

• **Abraham M. Ornsteen,** Philadelphia; University of Pennsylvania School of Medicine, 1917; age 83; died April 28, 1978. Dr. Ornsteen, emeritus professor of neurology at the University of Pennsylvania School of Medicine, was past chairman of the medical advisory board of the national Multiple Sclerosis Society.

• **Charles F. Posey;** Temple University School of Medicine, 1934; age 74; died May 4, 1978.

• **Allan G. Rewbridge,** Naples, Florida; Harvard Medical School, 1926; age 76; died May 9, 1978.

• **Henry Sigmond,** Melrose Park; University of Pennsylvania School of Medicine, 1928; age 75; died May 1, 1978. Dr. Sigmond, an orthopedic surgeon, was a staff member at Einstein Medical Center and Thomas Jefferson University, Rolling Hill, and John F. Kennedy hospitals.

• **Henry O. Sloane,** Deerfield Beach, Florida; University of Maryland School of Medicine, 1911; age 92; died April 4, 1978. He had practiced ophthalmology in Philadelphia for more than 50 years.

• **Charles N. Sturtevant,** Braintree, Massachusetts; graduated 1907; age 94; died May 20, 1978.

• **George J. Thomas,** Pittsburgh; Ohio State University School of Medicine, 1923; age 82; died May 27, 1978. He was an internationally known anesthesiologist who pioneered safety measures for operating rooms. Dr. Thomas had been chairman of anesthesiology at the University of Pittsburgh School of Medicine and director of anesthesia at St. Francis Hospital in Lawrenceville.

• **Charles A. W. Uhle,** Hockessin, Delaware; University of Pennsylvania School of Medicine, 1930; age 74; died June 4, 1978.

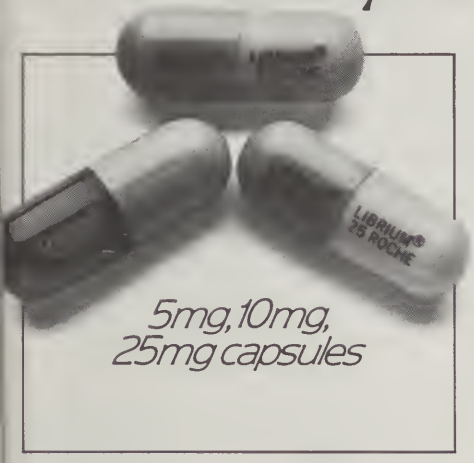
• **Richard K. D. Watanabe;** North Hills; age 56; died March 14, 1978.

• **Edward G. Werhun,** Wilkes Barre; Jefferson Medical College, 1956; age 48; died May 1, 1978.

• **Charles H. Yeutter,** Philadelphia; Temple University School of Medicine, 1933; age 70; died April 19, 1978. He had practiced family medicine in the Frankford area for 45 years.

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Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. Oral—Adults: Mild and moderate anxiety and tension, 5 or 10 mg t.i.d. or q.i.d.; severe states, 20 or 25 mg t.i.d. or q.i.d. Geriatric patients: 5 mg b.i.d. to q.i.d. (See Precautions.)

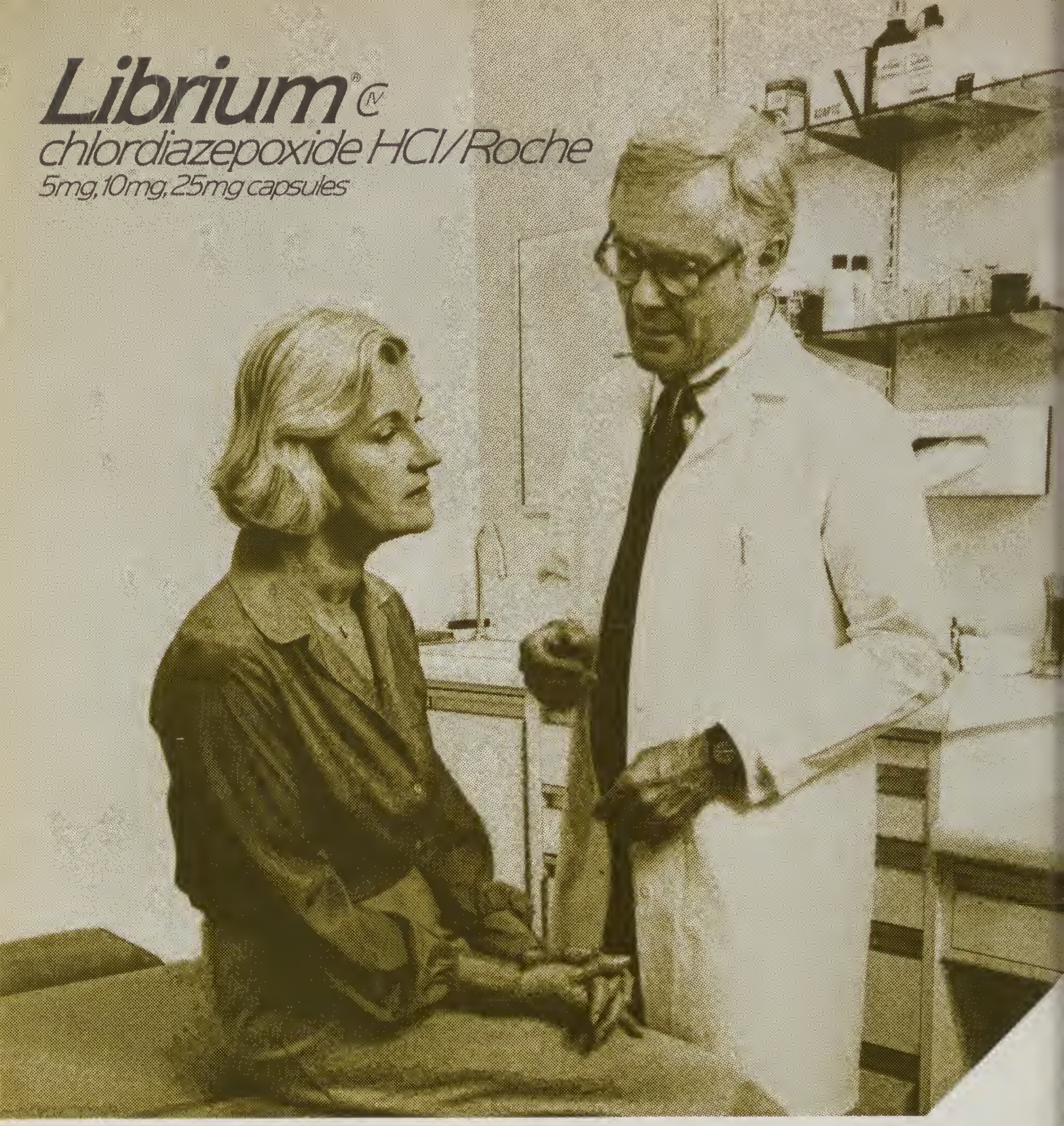
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Please see preceding page for a summary of product information.

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Pennsylvania Medicine

Vol. 81, No. 10
OCTOBER 1978



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John B. Lovette, M.D.
129th President
Pennsylvania
Medical Society

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When cystitis recurs... **Bactrim fights uropathogens**



at 3 important sites

the Bactrim three-system counterattack...

① urinary tract

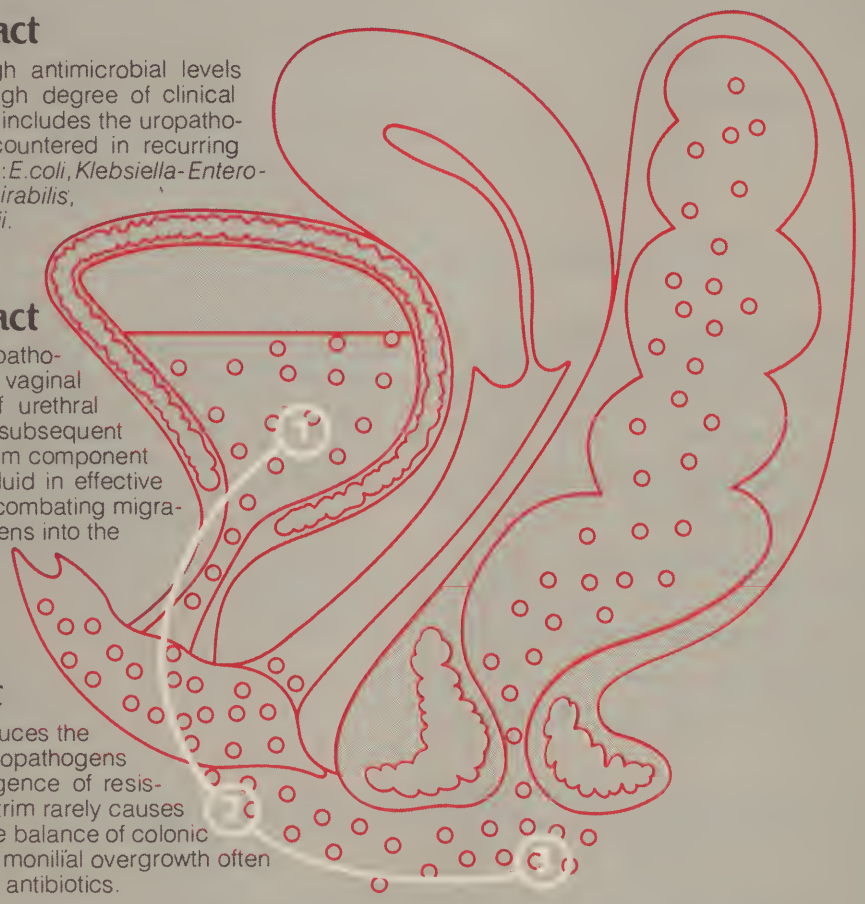
Bactrim provides high antimicrobial levels in the urine and a high degree of clinical efficacy. Its spectrum includes the uropathogens most often encountered in recurring urinary tract infections: *E.coli*, *Klebsiella-Enterobacter* and *Proteus mirabilis*, *vulgaris* and *morganii*.

② vaginal tract

Bactrim combats uropathogens colonizing the vaginal introitus, a source of urethral contamination and subsequent cystitis. Its trimethoprim component diffuses into vaginal fluid in effective concentrations, thus combating migration of urinary pathogens into the urinary system.

③ lower intestinal tract

Bactrim markedly reduces the colonic reservoir of uropathogens with negligible emergence of resistance. Moreover, Bactrim rarely causes adverse effects on the balance of colonic flora...seldom causes monilial overgrowth often associated with many antibiotics.



to clear her infection and combat reinfecting organisms

BACTRIM™ DS DOUBLE STRENGTH TABLETS

(160 mg trimethoprim and 800 mg sulfamethoxazole)

JUST ONE TABLET B.I.D. FOR 10 TO 14 DAYS

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Please see summary of product information on next page.



When cystitis recurs...

BACTRIM™ DS DOUBLE STRENGTH TABLETS

(160 mg trimethoprim and 800 mg sulfamethoxazole)

fights uropathogens at 3 important sites

- ☐ Highly effective against most urinary invaders
- ☐ Indicated even in presence of structural abnormalities and vesicoureteral reflux (so clinically significant in children)
- ☐ Indicated in patients as young as two months of age
- ☐ Dual action minimizes microbial resistance
- ☐ Generally well tolerated, with or without food
- ☐ Easy-to-follow b.i.d. dosage schedule
- ☐ During therapy, maintain adequate fluid intake; perform frequent CBC's and urinalyses with microscopic examination
- ☐ Contraindicated during pregnancy and the nursing period, in patients hypersensitive to its components and in infants under 2 months of age

ROCHE
Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Before prescribing, please consult complete product information, a summary of which follows:

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli, Klebsiella-Enterobacter, Proteus mirabilis, Proteus vulgaris, Proteus morganii.* **It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination.** *Note:* The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

Also for the treatment of documented *Pneumocystis carinii* pneumonitis. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.

The recommended quantitative disc susceptibility method (*Federal Register, 37*:20527-20529, 1972) may be used to estimate bacterial susceptibility to Bactrim. A laboratory report of "Susceptible to trimethoprim-sulfamethoxazole" indicates an infection likely to respond to Bactrim therapy. If infection is confined to the urine, "Intermediate susceptibility" also indicates a likely response. "Resistant" indicates that response is unlikely.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers; infants less than two months of age.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

Urinary tract infections: Usual adult dosage—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days.

Recommended dosage for children—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. A guide follows:

Children two months of age or older:

Weight		Dose—every 12 hours	
lbs	kgs	Teaspoonfuls	Tablets
20	9	1 teasp. (5 ml)	½ tablet
40	18	2 teasp. (10 ml)	1 tablet
60	27	3 teasp. (15 ml)	1½ tablets
80	36	4 teasp. (20 ml)	2 tablets or 1 DS tablet

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	½ the usual regimen
Below 15	Use not recommended

Pneumocystis carinii pneumonitis: Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: *Double Strength (DS) tablets,* each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100; Prescription Paks of 20. *Tablets,* each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40, available singly and in trays of 10. *Oral suspension,* containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole, fruit-licorice flavored—bottles of 16 oz (1 pint).

medigram

PMS HOUSE OF DELEGATES TO MEET IN LANCASTER

The 1978 Annual Session of the PMS House of Delegates will convene at 10 a.m., Monday, October 30, 1978 in the Baroque Ballroom of the Host Farm Resort Motel, Lancaster. Most councilor districts will caucus at 9 a.m. A delegates' buffet luncheon will be served following the opening session. Open hearings of reference committees will be held beginning at 1:30 p.m. Monday afternoon. All members are welcome to testify on issues under reference committee consideration. Delegates will receive the new Official Reports Book and other items for consideration the second week in October. The following resolutions were submitted by press time:

78-1: Revision of PMS Constitution and Bylaws. Asks the House to authorize a complete revision, possibly including a combining of the documents.

78-2: Medical School Delegate Expense. Calls on PMS to provide up to $300 per delegate to finance student delegates from Pennsylvania medical schools to the American Medical Student Association.

78-3: Medical Student Membership. Would establish a student membership category.

78-4: Terms of Office--Board of Trustees. Would limit the term of office of trustees to three years, with a limit of two consecutive terms.

78-5: Pennsylvania Senate Bill 1266. Asks PMS support for continuation of the nonreplacement fee in blood transfusions.

78-6: Minimum Standards for Mental Health Services. Calls for the establishment of minimum standards of care and nonparticipation by physicians in a delivery system that does not meet the minimum.

78-7: Better Involvement of PMS Membership in Making Decisions of Far-Reaching Consequence. Calls on the Board to make more effort to determine member sentiment before making decisions of far-reaching consequence.

78-8: Collateral Benefits in Medical Liability Actions. Calls for revision of the law to permit use of collateral benefits of the plaintiff as evidence in medical malpractice cases.

78-9: Taxing Unsuccessful Plaintiffs. Endorses the concept of assessing plaintiffs for the costs of a successful defense in medical malpractice cases.

78-10: PMS Involvement in the Regulatory Process. Calls for gubernatorial and legislative candidates to commit themselves to bringing order to the regulatory process.

78-11: Setting HMO Premiums through Competition. Asks the legislature to assure that HMO premiums will not be forced below market levels by administrative or regulatory means.

78-12: Suggested Hospital Planning Concepts. Asks public planning bodies to give reasonable consideration to the problems of the number of hospital beds and the obstacles to proper operation of the market mechanism.

78-13: Standards for Hospital Waiting Lists. Asks that before it is concluded that hospital bed capacity should be reduced, mechanisms be established to develop standards for providing hospital beds based on patients' needs.

ANNUAL STATE DINNER SITE OF HONORS, AWARDS

The Society's 31st Annual State Dinner is scheduled for Tuesday, October 31, 1978 at the Host Farm Resort Motel, Lancaster. All members are invited to attend as the Society installs John B. Lovette, MD, as president; and awards the past president's medal to John V. Blady, MD, and plaques to Board of Trustees members George A. Rowland, MD, who is retiring, and William C. Ryan, MD, who is resigning. Henry L. Bockus, MD, Philadelphia gastroenterologist, will receive the Society's Distinguished Service Award. The reception is at 7 p.m.; dinner at 8 p.m. Tickets are $18 for those not registered at the Host Farm. Registered guests will pay a $10 surcharge in addition to the daily rate for the American plan.

COURT UPHOLDS SUSPENSION OF DR. McCOY'S LICENSE

Commonwealth Court has upheld the State Board of Medical Education and Licensure which two years ago suspended the medical license of Orlo G. McCoy, MD, of Bradford County, for his refusal to carry malpractice insurance. This is the State Society's test case of the mandatory insurance provision of Pennsylvania's medical malpractice law. The decision has been appealed to the Pennsylvania Supreme Court. The stay on Dr. McCoy's license suspension continues pending the appeal.

STATE MD LICENSE RENEWALS DUE

The State Board of Medical Education and Licensure will mail biennial renewals to all doctors of medicine holding Pennsylvania licenses on October 19. A $75 renewal fee is required. Again this year a questionnaire will accompany the renewal. The new, improved questionnaire supplies raw data for the PMS Commission on Manpower in its studies and recommendations.

PHILADELPHIA PAC HOLDS CANDIDATES EVENING

The Philadelphia Political Action Committee invites all members of the Philadelphia County Medical Society, their spouses, and guests to participate in a National Legislative Candidates Evening at 7:30 p.m., October 23, 1978 at the Philadelphia County Medical Society Headquarters, 2100 Spring Garden Street. A program allowing each candidate to make a brief presentation will be followed by a reception. RSVP 563-5343.

PUBLIC HEALTH SERVICE RECOMMENDS ON INFLUENZA

The Advisory Committee on Immunization Practices of the U.S. Public Health Service has recommended an inactivated influenze vaccine for 1978-79. It will consist of the influenza viruses expected to be prevalent and is recommended for all individuals 65 years of age and older and those of any age with chronic conditions of the heart, lung or kidneys, diabetes, or other metabolic illnesses. The recommendations, derived from 1978 field trial observations, are summarized by age group below.

Vaccine Formulation	Age	Product Type	Dosage (ml)	Number of Doses
Adult*	over 26 yrs.	whole virion or subvirion (split virus)	0.5	1
Youth**	13-25 yrs.	whole virion or subvirion (split virus)	0.5	2***
	3-12 yrs.	subvirion (split virus)	0.25	2***
	6-35 mo.****	subvirion (split virus)	0.15	2***

*Contains 7 ug each of A/USSR/77, A/Texas/77, B/Hong Kong/72 hemagglutinin antigens

**Contains 20 ug A/USSR/77 and 7 ug each of A/Texas/77 and B/Hong Kong/72 hemagglutinin antigens

***4 weeks or more between doses; both doses essential for good protection

****Based on limited data. Since the likelihood of febrile convulsions is greater in this age group, special care should be taken in weighing relative risks and benefits.

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John B. Lovette, MD, to lead PMS as 129th president



It took John B. Lovette only six years to complete work on his baccalaureate and medical degrees. He worked in the coal mines of his native Cambria County while a student at St. Francis College, Loretto, to help his parents meet expenses. He did not have the benefit of the modern curriculum available in some of today's accelerated programs but relied on hard work and his will to complete his studies to achieve two four-year programs in six years.

The Johnstown surgeon will be installed as the 129th president of the Pennsylvania Medical Society October 31, 1978 at the Society's annual state dinner at the Host Farm Resort Motel, Lancaster. Earlier in the House of Delegates meeting, he intends to herald the dawn of a tenure without crisis, an unusual experience among recent PMS presidents.

Dr. Lovette said it's "good news" that the year ahead promises to be relatively calm. He believes the Society needs a quiet period in which to regroup, reorganize, and move on.

He views the coming year as a time for affirming the State Society as the "voice of medicine" in Pennsylvania, the vehicle by which physicians are heard as health care issues emerge.

"The Pennsylvania Medical Society and physicians' specialty societies in every state must join together to become directly involved in the problems of patient safety and risk management," he said. "We must establish leadership through our professional organizations and in Pennsylvania this means our medical society. Fortunately, the Pennsylvania Medical Society Liability Insurance Company, which we successfully established this year, gives us for the first time the opportunity to examine data on malpractice first hand, and the potential to reduce malpractice incidents to a minimum and to eliminate frivolous claims altogether."

Dr. Lovette also sees physicians, through their professional societies, as the leavening essential to any national health insurance legislation. "The present private health insurance system must be maintained to provide Americans with a free choice regarding medical care. My overriding concern is the preservation of the private practice of medicine. We should use this crisis-free period to plan and ultimately achieve this goal."

Cost containment is an issue directly tied to preservation of private practice, he believes. "PMS should urge physicians to pledge to keep fee increases to a point where the percentage of increase does not exceed the all services component of the consumers price index."

Twenty-five years of active service at all levels of organized medicine led Dr. Lovette to the conviction that active county medical societies and strong grass roots support of the American Medical Association are essential to the success of all programs supported by physicians.

"I point with pride to my own county medical society as an example of an active organization. We meet monthly, usually at dinner, and from this regular coming together, often with spouses involved, has emerged joint and individual commitment to support



the programs of the organization."

"Barney" Lovette became active in the Cambria County Medical Society early in his professional career, holding various offices including the presidency. He served as a delegate to the PMS House for 12 years, until he was elected vice speaker. When his good friend, William Y. Rial, MD, of Swarthmore, resigned as speaker of the PMS House to become vice speaker of the AMA House of Delegates, the PMS House unanimously elected Dr. Lovette to succeed him. He led the House of Delegates, whose members came to know him well and respect him, through the early years of malpractice crisis, and was elected vice president of the Society in 1976.

Dr. Lovette is as well known in the AMA House of Delegates as in its Pennsylvania counterpart. As vice chairman and chairman of the Pennsylvania Delegation, he helped to make the voice of Pennsylvania heard in the AMA House, and led the delegation in its successful effort to elect George A. Rowland, MD, chairman of the PMS Board of Trustees, to the AMA Board of Trustees this past June.

The pace John Lovette set for himself during his student days at St. Francis College and Pitt School of Medicine earned more for him than a medical degree predating his baccalaureate degree. He learned how to get jobs done. In addition to his activities in organized medicine, Dr. Lovette has found time to fill a public leadership role. He is vice chairman of the Board of Trustees at St. Francis College, on the Advisory Board of the University of Pittsburgh at Johnstown, and has been on the Board of Directors of the Chamber of Commerce. He is a member of the Greater Johnstown Committee, was president of the Sunnehanna Country Club, and is on the Advisory Board of the United States National Bank and the Board of Health, Westmont Borough.

He served for nine years as a member of the Westmont-Hilltop School Board, and with his late father, then a retired school administrator who was a member of the Spangler School Board, formed the only father/son school board team in the state.

Dr. Lovette is a board certified general surgeon, a fellow of the American College of Surgeons, a member of the Pittsburgh Surgical Society, a founding member of the Pennsylvania Thoracic Surgical Society, and a fellow of the American College of Chest Physicians, The Royal Society of Medicine, and the Pan Pacific Surgical Association.

A native of Hastings, in Cambria County, he interned at Conemaugh Valley Memorial Hospital in Johnstown, then served two years as a captain in the Army Medical Corps. He spent a year in the surgical division of the Graduate School of Medicine at the University of Pennsylvania in 1952-53, and three years as a teaching fellow in general surgery and as a research fellow in cardiovascular surgery at the Presbyterian University Hospital School of Medicine, University of Pittsburgh. He is chairman of the Department of Surgery at Mercy Hospital, Johnstown. He was chairman of the department and is now a surgical section chief at Conemaugh Valley Memorial Hospital, Johnstown. Six other hospitals benefit from his affiliation as a consultant or courtesy staff member.

Dr. Lovette and his wife, Kate, have a close family relationship with their four sons, all of whom are pursuing professions. Daniel, an attorney, and John B., II, a dentist, have established practices in Johnstown. Michael is in his third year at Temple University School of Dental Medicine, and David, having earned a B.A. degree at St. Francis College, is a first year student at the Temple School of Pharmacy. There are three grandchildren, Leigh Anne, Kara, and Katie.





Mrs. Manuel A. Bergnes (above right), Norristown, president of the American Medical Association Auxiliary, and Mrs. Howard F. Conn (above left), Uniontown, president elect of the Pennsylvania Medical Society Auxiliary, have key roles at the Auxiliary's convention in Lancaster October 29-November 1. An address by Mrs. Bergnes to the PMS House of Delegates and installation of Mrs. Conn as the 55th PMSA president will highlight the Auxiliary convention which is being held in conjunction with the 1978 Session of the State Society's House of Delegates.

State dinner honoree

Dr. Bockus named for PMS Distinguished Service Award

Henry L. Bockus, MD, of Philadelphia, world renowned specialist in gastrointestinal diseases, will become the eighth recipient of the State Society's Distinguished Service Award at the State Dinner Tuesday, October 31, in Lancaster. The award, in the form of a medallion, will be presented "in recognition of meritorious service in the science and art of medicine and for a public life and activities which reflect great credit on the profession."

Long dedicated to the idea that cooperation among medical men of many nations will promote world peace, Dr. Bockus in 1958 helped to found the World Organization of Gastroenterology and served as the organization's first president from 1958 to 1962. In addition, Dr. Bockus has served as chairman of the board of MEDICO (a service of CARE), the Medical International Cooperation group formed by the late Dr. Thomas Dooley and Peter Comandurus.

Dr. Bockus also is honorary president of the Bockus International Society of Gastroenterology, a group made up of 325 specialists in 21 countries. All members are former pupils of Dr. Bockus at the University of Pennsylvania Graduate School of Medicine, where he is emeritus professor of medicine and gastroenterology.

While establishing a distinguished career at the School of Medicine and Graduate Hospital, Dr. Bockus wrote a definitive three-volume text on gastroenterology which has been translated into several foreign languages. It is now in its third edition. He has written more than 170 scientific and clinical medical articles and is a member of the editorial boards of several medical publications.

He has received many awards and honors, including the Distinguished Service Award of the American Medical Association in 1970, the Strittmatter Award of the Philadelphia County Medical Society in 1957, the Caldwell Medal of the American Roentgen Ray Society in 1950, and an honorary fellowship of the Royal Society of Medicine in London. In addition, ten South and Central American countries and several in Europe and Asia have honored Dr. Bockus.

Henry Bockus began his career in 1917 as a graduate of Jefferson Medical College. He performed his internship at St. Luke's Hospital in Bethlehem and a residency in internal medicine (gastroenterology) at Lenox Hill Hospital in New York City. His long association with the University of Pennsylvania Graduate School of Medicine and Graduate Hospital culminated in his chairmanship of the university's department of internal medicine and gastroenterology.

Dr. Bockus is married to the former Rosalynd Foss and they have a daughter, Barbara Ann Aponte. The Bockuses reside at Rittenhouse Square in Philadelphia.

Dr. Bockus was selected unanimously to receive the award by a special committee of the Board of Trustees. Committee members are: A. Reynolds Crane, MD, chairman; William J. Kelly, MD; and David S. Masland, MD.

Emergency education clearinghouse formed

A clearinghouse for postgraduate education opportunities for emergency care physicians in Pennsylvania has been organized by the Philadelphia Health Management Corporation (PHMC) under a grant from the state Department of Health and the Pennsylvania Emergency Health Services Council.

The clearinghouse documents continuing medical education opportunities at hospitals, through organizations, and in other related institutions in the state that serve the needs of emergency physicians. The free information is summarized in calendar form listing programs by region and date.

Physicians are invited to inquire to: Clearinghouse, c/o Philadelphia Health Management Corporation, 530 Walnut Street,, Philadelphia, PA 19106; (215) 629-8252.

Related associations name officers

Members of the Pennsylvania Lung Association, the Pennsylvania Thoracic Society, and the Pennsylvania staff of the Congress of Lung Association recently held their 86th annual meeting in Philadelphia.

Officers for 1978-79 elected by the PLA are: Gerold J. Effinger, M.D., Penndel, president; Russell C. Appler, Paoli, first vice president; Richard I. Weller, Ph.D., Edinboro, second vice president; Annette A. Antoun, Harrisburg, secretary; and Geneva S. Klinger, Palmyra, treasurer.

Thoracic society officers are: Robert F. Johnston, M.D., Philadelphia, president; Frederick L. Jones, Jr., M.D., Danville, president elect; Sukhdev S. Grover, M.D., Pittsburgh, vice president; and G. William Atkinson, M.D., secretary-treasurer.

Legal counsel reports

Peer Review proceedings protected by decision

Fred Speaker, Esq.

Protection of peer review proceedings has just been won in a federal appellate court. In an opinion first published at the end of April 1978, the U.S. Court of Appeals for the Third Circuit (which includes Pennsylvania) upheld[1] the provisions of an Ohio statute[2] that is strikingly similar to Pennsylvania's Peer Review Protection Act.[3]

The case involved claims by a neurosurgeon of defamation and tortious interference with professional relations against two physicians who allegedly made statements to members of hospital staffs which resulted in refusal or limitation of hospital privileges. The plaintiff tried to take the depositions of six physicians and two hospital administrators, all of whom sought the protection of the Ohio statute.

After disposing of complex legal questions involving the choice of what law to apply and whether the Ohio statute could be applied retroactively, the Court considered whether the statute: (1) protected statements made during hospital staff privileges review of an application for membership; and (2) was constitutional. The Court answered each question affirmatively.

Addressing the plaintiff's argument that the statute grew out of the medical malpractice crisis and therefore had application only in such lawsuits, the Court nonetheless held that the statute "... is an explicit bar to the discovery of the proceedings of an Ohio committee reviewing an application for hospital staff privileges."[4]

The Court also found no merit in the plaintiff's contention that the statute violated his due process rights:

> Plaintiff asserts that O.R.C. §2305.251 deprives him of material necessary to establish his claims, effectively denying him access to the courts in violation of his Fifth and Fourteenth Amendments due process rights. Plaintiff argues that there is no compelling state interest served by the application of O.R.C. §2305.251 sufficient to overrule his interest in obtaining information about the review committee proceedings.
>
> The Ohio legislature has, however, concluded, presumably in that state's best interest, that the deliberations of medical review committees should be privileged. As one court has declared "[s]tate legislatures create privileges because a particular relationship is considered so valuable to society that it should be fostered by preserving the confidentiality of the relationship even though evidence which might aid in the quest for truth will be lost." *Baylor v. Mading-Dugan Drug Company,* 57 F.R.D. 509, 511 (N.D. Illinois 1972).[5]

Because the provisions of the Ohio statute are practically identical to Pennsylvania's, the opinion in this case from a court second only in stature in the federal system to the United States Supreme Court is most significant and helpful.

The author is a partner in the law firm of Pepper, Hamilton & Scheetz, which serves as the State Society's legal counsel.

[1] Samuelson v. Susen & Jannetta, *F.2d (No. 75-232, April 21, 1978).*
[2] *Ohio Revised Code §2305.251.*
[3] *63 P.S. §425.4*
[4] Samuelson v. Susen & Jannetta, supra *at p. 10.*
[5] Id. *at p. 11.*



State Society staff members received some "hands on" instruction in cardiopulmonary resuscitation by members of the Pennsylvania Chapter, American College of Emergency Physicians at Society headquarters on August 24 and 31. Paul Peindl, MD (above), of Beaver Falls, led the team of instructors at the first session. More than half the staff received American Heart Association certification in CPR following manual and written testing.

Office counseling

Child abuse: psychological antecedents and sequelae

Frederick J. Humphrey, II, DO
Larry Ackerman, MD
Evalyn Strickler, MSW

The Child Protective Services Act requires physicians and other professionals to report cases of suspected child abuse. These authors share some insights regarding the identification and management of child abuse. This is the ninth article in the office counseling series, a project of the departments of psychiatry of Pennsylvania's medical schools and the Pennsylvania Psychiatric Society.

With Kempe's publication in 1962 of "The Battered Child Syndrome,"[1] a new awareness and widespread interest in the problem of child abuse was stimulated. Many states promptly passed laws requiring that suspected child abuse be reported and that child protective services be formed within the community. In attempting to understand child abuse, many pediatricians and social workers emphasized the role of socioeconomic factors and the resultant environmental stress affecting parent-child interaction.

A serious and common shortcoming in identifying and managing child abuse is the failure to recognize the psychological disturbances that are invariably found in the abusing parent and the abused child. Consequently child abuse is regarded simply as a matter of deficient parenting skills requiring only a supportive, educative approach. As helpful as such services may be, they tend to minimize the psychopathology that underlies the problem of child abuse. Recent studies conceptualize child abuse as the result of three factors: the parent's abuse-prone personality, the child's abuse-provoking character structure, and environmental stress.

This paper reviews these etiologic factors and discusses the critical role of the physician in primary prevention and in diagnosis and management of child abuse.

Antecedents

Personality traits of the abuse-prone parent—In-depth evaluations of abusing parents reveal that abuse results from a severe dysfunction of parenting, and that in a significant number of cases the parents themselves were abused severely as children.[2] As a result of their early childhood experiences, the parents frequently have low self esteem and a poor self image, which is often coupled with emotional volatility, a low tolerance for frustration, and poor impulse control.

Abuse-prone parents, having experienced psychological deprivation as children, look to their children to supply the love and understanding they never received from their own parents. Thus they tend to "reverse roles" with their children, expecting to receive emotional nurturance from them. When the infant, toddler, or preschooler frustrates them by appropriately demanding love and requiring attention instead of fulfilling the parents' need for support, the parents become angry, rejecting, and punitive.

In scapegoating, the parents consciously or unconsciously identify the child as "bad" and thus the cause of family conflicts and discord. This is often the result of unconsciously identifying the child with "bad" qualities they perceive in themselves. Through such labeling, the children are subject to severe discipline, at times outright abuse, even when their behavior does not warrant the treatment. The child may come to represent a hated brother or sister, parent, current or previous spouse, or paramour. In cases of significant marital discord, anger felt toward the spouse may be directed to the child. The parent may blame the child for the marital conflict and feel that the spouse would be more loving if the child did not continually cause problems.

The combination of scapegoating and role reversal in a parent who is emotionally volatile and has poor impulse control places the susceptible child at tremendous risk. A supportive approach that is primarily educational does not deal with the underlying problem. Even if reportable physical abuse stops, the child often continues to be abused emotionally; such abuse makes it probable that the child will eventually become an abusing parent, thus perpetuating and multiplying the problem in successive generations.

Characteristics of the abuse-prone child—Any problem or defect in the child contributes to his being singled out as a scapegoat. Thus children who are mentally retarded, physically handicapped, have a delay in speech, or are physiologically hyperactive are more likely than their normal counterparts to be scapegoated and suffer the consequences of child abuse.

Another critical dimension in child abuse is the child's behavior and the way in which it triggers the abusive parental response. This factor is illustrated by the sequence of events that sometimes occurs when an abused child has been "rescued" and placed in what previously had been considered a good foster home. In these cases, it is

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commonly learned from the child, neighbors, or foster family that abuse has begun in the foster home. This experience may be repeated in successive foster homes. In such situations it is obvious that the child's behavior is a significant factor in precipitating the abuse.

Psychotherapy of abused children reveals how the child's repetitive and maladaptive behavior can contribute to child abuse within his family. This type of behavior may appear, for example, when the child whose predominant experience has been that adults are non-giving and punitive is treated intermittently by the family with kindness and love. The previous maltreatment has caused the child to expect abuse and to build up anger, feelings which are unacceptable when he is being treated in a positive manner. By behaving in a negative way, the child elicits the family's anger and in so doing creates a self-fulfilling prophecy in which he is able to discharge his anger overtly without experiencing inner conflict.

The child's repeated misbehavior can also be a way of reassuring himself that his parents are concerned. If, for instance, mother has been most involved with him when she is angry and least involved when he behaves well, acting out in "bad" ways may be the child's way of maintaining the needed relationship with mother.

Maladaptive behavior also may be a means of avoiding recognition of emotional needs, which are unacceptable because of the parent's tendency to reverse roles. The child who has learned that expression of his dependency needs has caused only pain in the past may be terrified of his wishes to be close and dependent. By misbehaving, and thereby provoking the parents' anger, the child creates a situation in which he no longer wants to be dependent on his parents, who are again abusive and rejecting. In this way, he can more successfully suppress the wish to be close and dependent.

Environmental factors—Environmental factors may play an important role in child abuse. Poverty and social isolation, for example, can aggravate the frustration of parenting adults, thereby increasing the possibility that they will strike out at a child who challenges their authority or who adds more stress to an already volatile situation.

If either parent has a major psychiatric disorder, such as schizophrenia, the likelihood of abuse is increased, for the parent's perception of the child may be influenced by a psychotic, delusional process. This may also affect the parent's ability to control impulses and to respond in a rational way to the child's demands. Physical illness of one or both parents, which usually places significant emotional stress on the family, also contributes to abuse.

Consistent lack of support on the part of one spouse or family member heightens the likelihood of abuse by contributing to a sense of isolation and loneliness in the remaining parent, who feels overwhelmed and resentful at having to take care of one or more children without relief or assistance. In such situations the parent may begin to see the child as the source of all his difficulty; the child is scapegoated and the parent avoids recognition of his role in his own problems. The abandoned parent may also displace his anger with the spouse or family onto the child. This anger is intensified when the child acts in a way similar to that of the spouse or family member who has abandoned them.

Sequelae

The physical sequelae of child abuse are recognized more easily by the physician than its emotional sequelae because the physical signs and symptoms are more easily observed. It is critical, however, for the physician to be sensitive and skilled in recognizing the emotional sequelae of child abuse, which include a poor self image, acute anxiety states, difficulty in relating to others, and self-destructive behavior.

The abused child typically has a poor self image. Over time, the child comes to accept the parents' view of him as being "bad," and often he feels that he deserves abuse. This negative self image often is accompanied by a significant impairment in the child's overall functioning; in particular, it often interferes with his ability to learn in school. These children are in a state of chronic heightened anxiety that interferes with their ability to concentrate and develop learning skills.

Children who are abused often experience acute anxiety, bordering on panic, in situations that others would not consider threatening. They anticipate criticism, rejection, and abuse from others to the degree that they panic when faced with even a mild rebuke, such as being corrected by a teacher.

Abused children usually show a significant impairment in their ability to relate to others. The experience of growing up with an abusive family inhibits the development of basic trust, which then impairs ability to establish satisfying relationships with others outside the family unit.

Statistics on the incidence of self-destructive behavior among abused children are alarming. A recently published study of physically abused children disclosed that 40 percent were self destructive or overtly suicidal.[3]

Emotional abuse

Emotional abuse is similar to physical abuse in that the child is repeatedly and actively traumatized by the parents or guardians; verbal and emotional abuse can be just as traumatic as physically hurting the child. Physical and emotional abuse are often associated, but frequently remain undetected because the physical abuse is not so severe that the child requires medical attention. A factor that has discouraged the reporting of emotional abuse is the difficulty in differentiating between disturbed behavior in children due to emotional abuse and behavioral disorders caused by other factors.

Emotional abuse is found in many forms. The emotionally abused child may be scapegoated to the degree that nothing he can do will be seen as "good" or acceptable to the parents. Parents also may emotionally traumatize their children by subjecting them to unreasonable or sadistic punishments that clearly exceed the needs of any disciplinary system. Such punishment includes extreme ridicule or embarrassment.

A child is emotionally abused when his parents are so detached and unsupportive that they severely criticize him when he goes to them for help. This is often the case when the parents view the child as being responsible for all of their problems and therefore as undeserving of their sympathy.

Emotional injury also occurs when a parent covertly supports the child's propensity for a particular behavior, but then severely punishes the child when he displays the behavior. For instance, some parents take a certain pride in the destructive or delinquent behavior of their child, yet severely and even sadistically punish the child when he is caught.

Another type of psychological abuse occurs when parents repeatedly build up their child's hopes only to dash them abruptly and traumatically. An example is the parent who is separated from a child, who promises that they will visit or do certain things together, and then repeatedly and unaccountably fails to show up at the appointed time, leaving the child confused and distraught.

Finally a child is emotionally damaged by the parent who actively prevents the child from developing normally by thwarting all attempts to separate and develop appropriate independence from the family.

Evaluation and treatment

The primary care physician is in an optimum position for detecting cases of child abuse; not only is he most likely to encounter the overt signs of physical abuse, but his continuing interaction with the family allows him to recognize the more subtle indicators of emotional trauma. This ongoing contact with the family gives him a diagnostic advantage over emergency room and child welfare personnel, who most often see the child in single, isolated circumstances. Moreover the physician's longitudinal perspective of the child's behavior and the family's interaction place him in a key position for preventing child abuse. He can intervene when the child's behavior begins to be maladaptive and when family interaction appears to be disturbed and suggestive of potential child abuse. It is important to keep in mind, however, that primary prevention can be effected only when the physician carefully assesses for the emotional antecedents of child abuse rather than simply observing the presence of physical manifestations.

If the physician feels that there is potential for child abuse within the family, he can intervene with the familiar counseling skills of problem identification, careful listening, clarification, education, guidance, and reassurance. He may also find it appropriate to refer the parents to Parents Anonymous or another supportive group.

When the physician suspects that the situation has evolved to a point at which the child is being abused, he is required by law to report both physical and emotional abuse to the county child welfare agency. The physician who reports child abuse is guaranteed anonymity and is not required to investigate the situation further.

When child abuse is strongly suspected or established, it is important that the child and family have a complete psychiatric evaluation and appropriate psychotherapeutic intervention. To neglect the psychological conflicts of the abusing parents is to rely on superficial change which may prevent further physical abuse but will not prevent further emotional abuse. If the child does not receive psychotherapy, the sequelae of child abuse will remain unaltered, which all too often means that the battered child becomes the abusing parent of the subsequent generation.

Summary

Child abuse constitutes a psychiatric emergency. It is far more than a socioeconomic problem requiring only supportive, educative management. It represents a serious psychiatric disorder. The etiology varies; it may include environmental factors, psychopathology in the parents that often stems from their own early development, and maladaptive behavior in the child that often precipitates and maintains the abuse.

The family physician, by being sensitive to these factors, can detect the potential for physical and emotional abuse. In terms of primary prevention, the family physician's role as a trusted advisor allows him to help the family develop appropriate childrearing and disciplinary methods. When abuse is evident, the family physician is in a unique position to support the family in obtaining the needed psychiatric evaluation and treatment. □

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Situation changing on doctrine of *res ipsa loquitur*

Fred Speaker, Esq.

The law of medical malpractice in Pennsylvania with respect to the doctine of *res ipsa loquitur*[1] has been clear—it is not applicable except in highly unusual circumstances. That state of the law now is under serious attack.

More than two decades ago the Pennsylvania Supreme Court set forth the rule that:

> . . . no presumption or inference of negligence arises merely because the medical care or surgical operation terminated in an unfortunate result which might have occurred even though proper care and skill had been exercised, and where the common knowledge or experience of laymen is not sufficient to warrant their passing of judgment. In such cases the doctrine of *res ipsa loquitur* or of exclusive control may not be invoked, and expert testimony in support of the plaintiff's claim is an indispensable requisite to establish a right of action.[2]

After reviewing previous cases it had decided, the Court went on to say:

> It is thus abundantly clear that since, in all such malpractice cases involving an appraisal of the propriety and skill of a doctor or surgeon in his professional treatment of a patient, a lay jury would presumably lack the necessary knowledge and experience to render a just and proper decision, they must be guided by the testimony of witnesses having special or expert qualifications. The only exception to this otherwise invariable rule is in cases where the matter under investigation is so simple, and the lack of skill or want or care so obvious, as to be within the range of the ordinary experience and comprehension of even non-professional persons. . . . It would be a matter of common knowledge and observation that such things do not ordinarily attend the service of one exercising ordinary skill and experience in the work of surgery because they involve ulterior or extraneous acts or omissions the judgment of which would not require scientific opinion.[3]

By 1964 the American Law Institute had adopted a revision of its "Restatement of the Law of Torts" which contained the following provision:

> § 328 D. Res Ipsa Loquitur
>
> (1) It may be inferred that harm suffered by the plaintiff is caused by negligence of the defendant when
>
> (a) The event is of a kind which ordinarily does not occur in the absence of negligence;
>
> (b) other responsible causes, including the conduct of the plaintiff and third persons, are sufficiently eliminated by the evidence; and
>
> (c) the indicated negligence is within the scope of the defendant's duty to the plaintiff.
>
> (2) It is the function of the court to determine whether the inference may reasonably be drawn by the jury, or whether it must necessarily be drawn.
>
> (3) It is the function of the jury to determine whether the inference is to be drawn in any case where different conclusions may reasonably be reached.[4]

Despite the adoption of this provision, the Pennsylvania Supreme Court several years later once again cited the *Robinson* case and said:

> As a matter of proof in malpractice cases, there is no presumption or inference of negligence merely because a medical procedure terminated in an unfortunate result which might have occurred despite the exercise of reasonable care. This is especially so where the treatment and injury involved are such that common knowledge or experience of laymen is not sufficient to form the basis for passing an intelligent judgment. In such cases, expert testimony in support of the plaintiff's claim is an indispensable requirement to establish a right of action.[5]

The importance of the rule that the doctrine of *res ipsa loquitur* is not to be used in medical malpractice cases is almost self evident. Fundamentally it means that a plaintiff must be able to produce an expert witness to testify that there was an absence of proper care and skill—or lose the case. It was perhaps the importance of this question that led some fifteen states to modify the *res ipsa* rule by statute.[6]

Implications in Pennsylvania

Because of the persistence of the rule against the use of *res ipsa loquitur* in Pennsylvania, it was determined that there was no need for the Pennsylvania Medical Society to support

[1] Res ipsa loquitur *literally means "the thing speaks for itself."*

[2] *Robinson v. Wirts, 387 Pa. 291, 294-5 (1956).*

[3] Id. *at 297-8.*

[4] *RESTATEMENT (SECOND) OF TORTS §328 D (1965).*

[5] Collins v. Hand, *431 Pa. 378, 383 (1968).*

[6] *5 AMA, State Health Legislation Report, No. 1, p. 7 (Supplement II December, 1977).*

The author is a partner in the law firm of Pepper, Hamilton & Scheetz, which serves as the State Society's legal counsel.

legislation to that effect in the Commonwealth. However, recent judicial opinions may have made that determination obsolete.

Less than three and a half years ago, the Pennsylvania Supreme Court decided the case of *Gilbert v. Korvette's Inc.*[7] Although the case did not involve any charge of medical malpractice—it was a claim against a store and an elevator company for personal injuries suffered by a three-year-old child when he attempted to alight from an escalator—the Court did say that:

> . . . this Court accepts the persuasive authority of the Restatement, and we adopt section 328 D as the law of this Commonwealth.[8]

In 1977 two medical malpractice cases were considered by courts of common pleas in Pennsylvania and expressly followed the *Korvette* decision, holding that the Restatement rule was applicable in medical malpractice cases.

The first case,[9] decided in Beaver County, involved a suit by a young steelworker against a hospital, three physicians, and a nurse anesthesist. The plaintiff claimed that he had been in good health except for abdominal pains, that one of the defendants performed an exploratory laparotomy on him, and that shortly after reviving from the anesthetic he felt heaviness in his shoulder and severe pain, resulting in the total loss of use of his muscles in his arm between his elbow and shoulder.

The Court applied the doctrine of *res ipsa loquitur* in rejecting a defendant's preliminary objections, saying:

> We conclude that our Supreme Court intended the *Restatement* section 328D apply to medical malpractice cases as well as other negligence actions. We now find that plaintiff's complaint presents a prima facie case for the application of the section. An injury to a healthy part of a patient's body, not the subject of treatment, appears unlikely to occur in the absence of negligence. The unconsciousness of plaintiff in the custody of defendants seems to eliminate other possible causes of his injury. Obviously defendants had duties of due care toward plaintiff while treating him.

The second case,[10] decided in Dauphin County, involved a suit by a woman against a hospital, her physician, a resident doctor, and a nurse anesthetist. The plaintiff, in good health except for some gynecological problems, was given general anesthesia and placed in a position with her head and shoulders lowered. The doctors did a dilatation and curettage, performed a laparoscopy, and did a laparotomy; upon recovery, the plaintiff discovered that she had suffered a left suprascapular nerve palsy. At trial, the jury awarded her $56,000.

The Court, in rejecting a call for a new trial, observed that:

> Although plaintiff's expert testified that the shoulder injury resulted from a malposition during Mrs. Jones' sojourn in the operating room, there was no direct evidence as to precisely how this occurred and the principle theory of the plaintiff was based on *res ipsa loquitur*.[11]

Relying on the Pennsylvania Supreme Court's holding in the *Korvette* case, the Court went on to emphasize that:

> Indeed, the instant case presents a classic situation for the application of *res ipsa loquitur*. The wife/plaintiff claims to have been injured while under the care of the various defendants. She cannot aver the precise conduct of the defendants because she was unconscious during the time of her injury although the circumstantial evidence points strongly toward the negligence of one or more of the parties sued. The evidence clearly satisfies the requirements of § 328 D.[12]

It is understood that this case, at least, is being appealed. Until there is an appellate court decision, the law articulated in these two cases binds only parties in Beaver and Dauphin counties. But the danger and threat to physicians posed by these two cases is clear and should be resisted by organized medicine.

[7] *457 Pa. 602 (1974).*
[8] Id. *at 611-12.*
[9] Anderson v. Zernich Clinic, *36 Beaver L. J. 26 (1977).*
[10] Jones v. Harrisburg Polyclinic Hospital, et al., *99 Dauph. Rep. 274 (1977).*
[11] Id. *at 276.*
[12] Id. *at 277.*

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Schedule of Events
Registration: 8:15 a.m. - 9:00 a.m. - Main Lobby
Industrial Exhibits - The Stable

SYMPOSIUM ON STOMACH AND PANCREAS - Wyoming Room

Presiding: **H. Stuart Irons, M.D., FACS**
Chief, Surgical Service, V.A. Hospital, Wilkes-Barre, Clinical Professor of Surgery, Temple

9:00 a.m. Management of Chronic Pancreatitis
Herbert B. Greenlee, M.D., FACS
Chief, Surgical Service, VA Hospital, Hines, Illinois, Professor of Surgery, Loyola

9:40 a.m. Pancreatitis, Peritonitis With Remote Organ Failure
Arthur E. Baue, M.D., FACS
Donald Guthrie Professor of Surgery and Chairman, Department of Surgery, Yale

10:20 a.m. Reconstructive Operations for Post-Gastrectomy Disorders
LeRoy H. Stahlgren, M.D., FACS
Director of Surgery, Episcopal Hospital, Philadelphia, Professor of Surgery, Temple

SYMPOSIUM - ORTHOPEDIC TRAUMA SECTION - Lehigh Room

Presiding: **William A. Steinbach, M.D., FACS,** Scranton

9:00 a.m. Orthopedic Surgery and Hemophilia
Robert B. Greer, III, M.D., FACS
Chief, Division of Orthopedic Surgery, Milton S. Hershey Medical Center of the Pennsylvania State University

9:30 a.m. Total Shoulder Arthroplasty
Alan H. Wilde, M.D., FACS
Chairman, Department of Orthopedic Surgery, Cleveland Clinic

10:00 a.m. Immobilization of the Fractured Spine by Operative Instrumentation (Harrington Rodding)
Robert N. Clark, M.D.
Professor of Orthopedic Surgery, University of West Virginia

10:30 a.m. Modern Assessment of the Spinal Cord Injured Patient
William A. Black, Jr., M.D., FACS, Scranton
Chairman of the Governor's Committee on Spinal Cord Injury

11:00 a.m. Coffee Break - The Stable (Courtesy of Exhibitors)

11:15 a.m. TPN for GI Tract Rest
Stanley D. Dudrick, M.D., FACS
Professor and Chairman, Department of Surgery, University of Texas Medical School at Houston

12:00 noon Cocktails - Garden Terrace

12:30 p.m. Luncheon - Garden Terrace
Presentation: Drug Abuse as an Emergency Room Problem
Anthony Douglas, B.Sc.
Consultant, Drug and Alcohol Abuse Program of Luzerne County and State Department of Justice, Bureau of Corrections

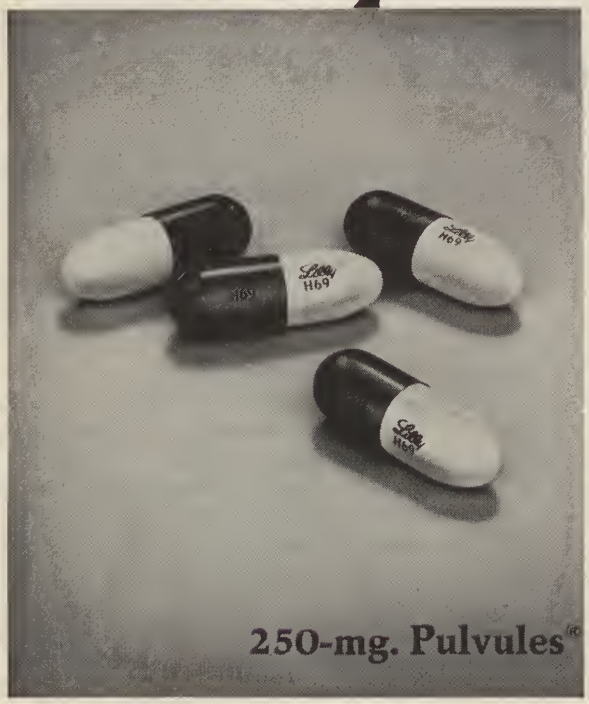
2:00 p.m. Panel on Pre and Post Operative Problems - Wyoming Room
Moderator: **Arthur E. Baue, M.D.**
Overview of Post Operative Problems, 1978
Misinterpretation of Upper GI Symptoms
Leroy H. Stahlgren, M.D.
Rational Use of Antibiotics
Herbert B. Greenlee, M.D.
TPN in Pre and Post Operative Management
Stanley D. Dudrick, M.D.

2:00 p.m. Panel of Spinal Cord Injury - Lehigh Room
Moderator: **William A. Steinbach, M.D.**
Speakers: **Robert B. Greer, III, M.D.**
Alan H. Wilde, M.D.
Robert N. Clark, M.D.
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Chairman clarifies

PMS Impaired Physician Committee philosophy outlined

Abraham J. Twerski, MD

In the past few years there has been an increasing emphasis on the "Impaired Physician" problem, and many state and local medical societies have developed programs to deal with this difficulty. A few months ago the Pennsylvania Medical Society established an Impaired Physician Committee whose function is described in last month's issue of PENNSYLVANIA MEDICINE.

"Impairment" is a broad term which can be applied to various conditions, such as depression, senility, sexual deviation, etc. The major thrust of impairment programs, however, has been to deal with problems resulting from physicians' addictions to alcohol, sedatives, and narcotics.

The reason for this emphasis is twofold. First, conditions such as senility and depression, because they are less stigmatic and less concealable, are more easily identified and brought to light by family and colleagues. In contrast the "cover up" in alcoholism or addiction tends to involve not only the addicted person, but also family and colleagues who hesitate to "point a finger" or jeopardize the physician's professional career. Second, there are studies indicating that the incidence of addiction among physicians is significantly greater than in the general population.

It should be noted that addiction is addiction is addiction, and that it is of little consequence whether the addictive substance is alcohol, barbiturates, Valium, Demerol, Talwin, or any of the myriad mind-altering substances available. Cross-tolerance has been demonstrated pharmacologically, and cross-dependence has been demonstrated behaviorally.

Addiction to alcohol or other chemicals significantly resembles carcinoma. The onset is apt to be insidious, often with an imperceptible transition from "social" drinking to addictive drinking. When symptoms of dysfunction occur, addiction, like cancer, may require quite radical therapeutic intervention. The condition may have domestic, occupational, and social "metastases"; and if permitted to progress too far, severe hepatic or cerebral deterioration may render the case hopeless.

It is a fairly safe generalization that addiction arises when alcohol or other chemicals are used to relieve the tensions and pressures generated by frequent encounters with stressful reality situations. Stress is a subjective phenomenon and is highly relative, ranging from major trauma to the annoyance of missing a bus. As anodynes, alcohol or other mood-altering substances are often used to relieve the discomfort of self-consciousness in a social situation or that of feelings of inadequacy when encountering a challenge. Although such feelings often are unjustified, their existence makes one feel incapable of coping with a given reality situation and tempts one to turn to chemicals for a sense of tranquility.

The use of alcohol, tranquilizers, or sedatives for the relief of normally occurring tensions virtually assures development of addiction. The law of tolerance is as immutable as the law of gravity, and dictates that the vast majority of chemicals which depress the cerebral cortex have a progressively decreasing effect as the central nervous system accommodates to them. After a period of time, the sought after relief can be obtained only by increasing the quantity of the substance or switching to a more potent chemical. Because normally occurring tensions rarely decelerate, and most often increase or remain constant, it is evident that the attempt to counter these feelings by chemical means is an open invitation to addiction.

In addition to the stresses of life to which everyone is subject, many physicians carry a stress load which is greater both qualitatively and quantitatively. The physician's responsibility is of ultimate gravity: the life of a human being. This responsibility does not end at 5 p.m., nor does it disappear over the weekend. The fact that all human life inevitably ends involves physicians with patients who die and, because our culture tends to look at every death as a therapeutic failure (as attested to by the calling of cardiac arrest on terminal cases), there is a built-in incidence of failure in many physicians' lives. Add to this the constant threat that lack of a successful outcome may give rise to the harrassment of malpractice charges, and you have a person, a physician, living in a fairly constant state of tension.

The unrealistic expectations of patients often are equalled by the physician's unrealistic view of himself as being omnipotent. As a healer and reliever of suffering, the physician may feel it is his function to alleviate all sorts of discomfort; when patients' complaints of pain or tension are persistent, the physician often faces the dilemma of either subjecting the patient to addictive analgesics and sedatives or seeing himself as derelict or deficient in fulfilling his duties. Either solution may render the physician vulnerable to addiction, because sanctioning prolonged chemical relief for others may imperceptibly reflect back on himself, while denying others the relief they persistently seek may intensify the physician's feelings of inadequacy and lead him to the anesthesia of alcohol or drugs to seek his own escape.

The omnipotent role into which the physician has been cast presents yet another difficulty: the physician is less likely to seek help with his feelings. Because asking for help sometimes is considered a betrayal of character weakness, it is inconsistent with this "superman" image. Instead of seeking help, the physician may seek more frequently the relaxation pro-

Dr. Twerski, chairman of the State Society's Committee on the Impaired Physician, is medical director of the Gateway Rehabilitation Center and clinical director of the department of psychiatry at St. Francis General Hospital, Pittsburgh.

vided by the occasional drink or, with unlimited access to drugs, he may self-medicate. Once the crossover into addiction has occurred, the same fantasy of omnipotence intensifies the denial that is so characteristic in alcoholism or sedative addiction, and the physician may turn a deaf ear to the entreaties of family and colleagues.

Ironically the very sensitivity of the physician's role that makes alcoholism or other addictions so lethal to his professional survival militates against early recognition and therapeutic intervention. The addicted physician, concerned that discovery of his problem might jeopardize his practice, is apt to try to conquer his problem alone. He frequently resolves to abstain "beginning tomorrow," and falls prey to that ever-receding tomorrow. His spouse, equally fearful that exposure might result in loss of economic security for the family, may refrain from bringing the problem to anyone's attention, and may instead resort to all the futile pleas, threats, and manipulations characteristic of the alcoholic's spouse.

The above combination of factors fostering denial and perpetuation of alcohol and chemical abuse account for the classification of addiction among physicians as an occupational hazard.

The purpose of the Pennsylvania Medical Society's impaired physician program is to provide help at any stage, but particularly to be available to the physician before he reaches the point at which the problem causes a dysfunction that not only threatens the public, but also jeopardizes the physician's professional career. The program, functioning as a totally non-punitive resource, will try to help the impaired physician by early intervention to achieve recognition of the problem and to provide appropriate referral for optimum treatment.

editorials

Hew's second opinion cost reduction questioned

Reminiscent of Pennsylvania Insurance Commissioner Herbert Denenberg's campaign against "unnecessary surgery" several years ago, the Department of Health, Education, and Welfare recently committed itself to the establishment of a second opinion program for medicare patients as a national solution for the elimination of this alleged "problem."

Debate about the worth or worthlessness of second opinions has produced a number of valid observations. The American College of Surgeons statement on "unnecessary surgery" recognizes that "consultation is a common and desirable part of good surgical practice . . ." Further, if either the physician or the patient is uncertain of the recommended mode of treatment or if the procedure involves extended disability, a second opinion ought to be sought. Others have expressed a hope that second opinion programs might recognize and eliminate "unnecessary surgery" at a substantial cost saving for third party payers and their subscribers and encourage non-operative management of medical problems.

It has been pointed out that conflicting opinions may be rendered due to honest differences in the practice of medicine. Such disagreement, however, does not indicate absolutely or relatively that the surgery is "unnecessary." The second opinion may or may not be more accurate than the first. If the second surgical opinion is rendered by a physician engaged in the practice of medicine, albeit another field, professional expertise may be diminished. This is one of the criticisms leveled by the director of the American College of Surgeons, C. Rollins Hanlon, MD. In response to HEW's suggestion that perhaps a surgeon ought not to be the consultant for a second opinion, he points out that the consultation program would not "arrive at some uniformity of informed expert opinion" but rather develop with a bias against surgical treatment.

To determine whether second surgical opinions will identify or reduce inappropriate surgery, Pennsylvania Blue Shield's Surgical Consultation Program was begun in January 1976 and expanded in October 1976. Blue Shield spokesmen said at that time that the program was, and would continue to be considered, a pilot project. It was anticipated that another two to four years of study would be required to obtain and evaluate sufficient data.

A similar paid second surgical opinion program was offered by the Associated Hospital Service of New York, Blue Cross-Blue Shield. It also was begun in January 1976 and was expanded in August 1976. Preliminary data, tallied in December 1976, showed that only a small fraction of subscribers took advantage of this program.

If the second opinion pilot studies are still incomplete, one wonders upon what foundation and for what reason HEW proposes to institute this plan nationally. As yet it has not been proven to be a solution. In fact, the term "unnecessary surgery" has not been defined. Moreover, at the time of this writing, the second opinion, even when it differs from the first, is not sufficient basis from which to infer that the recommended surgery is unnecessary.

It appears unlikely that the *mandatory* second opinion program will be a significant cost reduction factor nor that it will contribute to improved quality of patient care except in isolated cases. An in-depth diagnostic work-up and consultation with an appropriate expert when either the physician or the patient doubts the recommended treatment plan constitutes acceptable medical practice.

As we enter into another costly government program which fosters unnecessary public distrust of medical care, perhaps HEW would do well to review the results of this new program on a continuing basis to determine its value to the patient, and to terminate the program if it proves to be of minimal benefit.

David A. Smith, MD
Medical Editor

Community resources valuable in treating alcoholics

Richard W. Esterly, M.H.S.
Sister Rita Moriarty, S.C.C.

Alcoholism is a complicated illness of body and mind. It is psychologically characterized by denial, rationalizations, and alibis. When treatment is professional and multidisciplined, as outlined in the article on page 33 of the July issue of PENNSYLVANIA MEDICINE, recovery is not only possible, but probable.

The physical and psychological complexity of alcoholism withdrawal and treatment and the required time for specialized counseling and educational programs indicates the need for a coordinated effort of treatment using many community resources. Detoxification should occur under the supervision of qualified medical personnel. Alcoholism counselors must be available to motivate the individual and to develop an individualized treatment plan involving both the alcoholic and the family. This will involve a combination of medical, psychological, and social treatments on an outpatient or inpatient basis. Total treatment generally requires a minimum of two years of decreasing intensity. The physician is the coordinator of treatment, working closely with the other health professionals in the community.

Treatment resources

The American Hospital Association and other professional groups estimate that 20-30 percent of all medical-surgical beds are occupied by alcoholics, mostly with a nonalcoholic diagnosis. Other studies indicate that alcoholic patients in the physician's office will be there for reasons other than their alcoholism. The number of alcoholics in a caseload indicates the necessity to become familiar with the treatment resources in the community.

The physician should refer an alcoholic, after the diagnosis has been made, based on the signs and symptoms indicated in this article. The patient should be confronted with the facts of the diagnosis and of the treatment available. A specific appointment with a person in a local program should be made at that time. The psychological nature of alcoholism indicates that resistance can be expected. The physician can obtain names and telephone numbers of interested members of Alcoholics Anonymous. They will be available to meet with a patient and ease the transition into treatment.

The alcoholic in the Harrisburg area is served by a coalition of service providers which involves the area hospitals, physicians, Alcoholism Services, Inc. (A.S.I.), Hamilton Health Center, and other health and social agencies. Holy Spirit Hospital provides an inpatient detoxification unit and Alcoholism Services, Inc. provides a variety of nonhospital inpatient and outpatient modalities. If the patient is evaluated to need the intensity of hospital treatment, then he or she will be promptly admitted. The detoxification will be supervised by a skilled nursing team under the direction of Dean Olewiler, M.D. the chief admitting physician. The case workers develop an individualized treatment plan which involves some combination of further inpatient and outpatient care for the alcoholic patient and the family.

The following guidelines adopted by the AMA are used by Holy Spirit for the admission to the hospital.

1. A patient who is diagnosed as "alcoholic" by a physician, or who is so known by the hospital, or by other responsible agencies and individuals, should be admitted if he:
   a. has an infectious disease.
   b. has hyperthermia.
   c. has a history of convulsions, or a poorly controlled convulsive disorder and has been drinking.
   d. is hemorrhaging or unconscious.
   e. wants to be withdrawn from alcohol, either for the first time or after having relapsed to drinking.
   f. has a disulfiram alcohol reaction.
2. A person is diagnosed as "alcoholic" by a physician, or who is so known as an alcoholic patient, as the case may be, when he:
   a. is unconscious and has been drinking.
   b. is agitated and tremorous to the extent of indicating an acute withdrawal syndrome.
   c. has convulsions, hallucinations, or delirium tremens, manifesting a complicated withdrawal state.
   d. is suffering from a disease recognized as related to alcoholism (e.g., cirrhosis, neuropathy, pancreatitis) and wishes to be withdrawn from alcohol.
   e. has a disease or posttraumatic injury usually not requiring hospitalization, but also has a history of prolonged drinking, or of heavy ingestion of alcohol immediately prior to the illness.

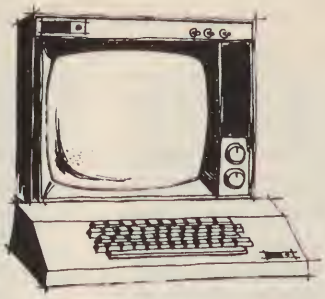
In accord with hospital policy, the family physician has the option of admitting the patient to the unit or referring the patient to the designated unit staff physician.

Non-hospital treatment

Alcoholic patients who do not need the intensity of the hospital, may be referred to a program similar to A.S.I. in the community. At A.S.I. the patient will be detoxified under the medical supervision of Robert G. Little, M.D., medical director, educated about the nature of the illness, counseled about treatment alternatives, and have a specific treatment plan developed. The person may be referred to A.S.I.'s 30-90 day inpatient program, the outpatient program, and/or Alcoholics Anonymous.

Special treatment concerns

Most of the limited knowledge of alcoholism is based on middle or late stage male alcoholics. Females and youth represent treatment populations that need special considerations.



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Adolescent and teenage alcoholism tends to present its own set of problems. By definition, alcoholism is characterized by an interference with normal functioning by alcohol abuse. Young persons, however, have not yet necessarily achieved a stable existance, so it tends to be difficult to isolate areas where alcohol and other drugs present a disruptive influence. Physical indicators of alcoholism become evident over a period of years, yet because of more critical nutritional needs during early growth periods, disorders are telescoped into two or three years.

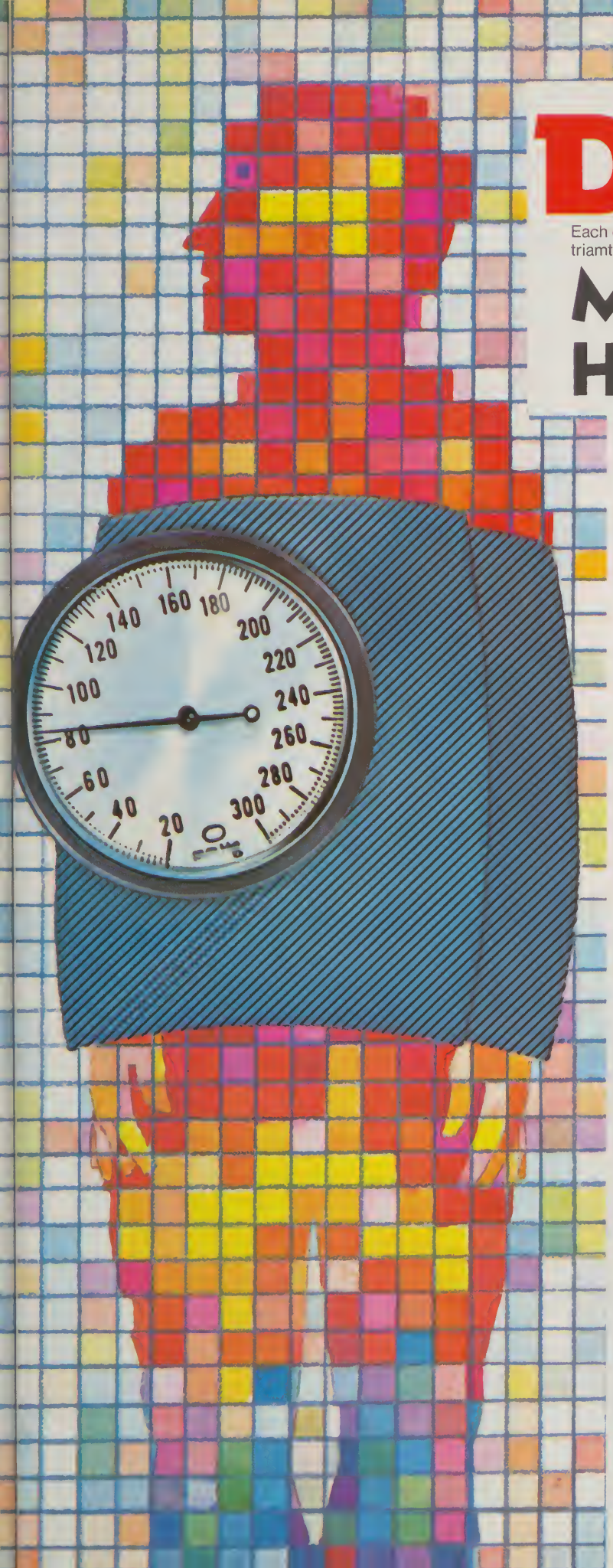
Evidence indicates a higher incidence of youthful drinking and a higher rate of consumption per occassion. The attitude of many parents that they would rather have their children use alcohol than "drugs" could be a contributing factor to the problem.

The female alcoholic too often shares a conspiracy of silence with family and friends, those most able to promote treatment. A number of special concerns emphasize the importance of having physicians using their prestige and influence to confront the fact of female alcoholism. These concerns include the following:

1. Alcoholic mothers may deprive children of affection, nurturing, and stimulation.
2. Recent studies indicate that a susceptibility to alcoholism may be inherited.
3. Women who drink alcohol during pregnancy risk bearing physically and mentally deficient offspring.
4. A strong possibility of polyaddiction exists.

This complex illness responds well to a comprehensive community approach that insures continuity of care. A team of professionals, each providing individual expertise, will dissolve the stigma associated with alcoholism, promote a broader understanding of the nature of the illness, and encourage persons who would benefit from treatment to accept responsibility for their illness and take appropriate action.

Mr. Esterly is executive director of Alcoholism Services, Inc., Harrisburg. Sister Rita is director of nursing services at Holy Spirit Hospital, Camp Hill.



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1. Goldberg HL, Finnerty RJ, Cole JO: Doxepin: Is a single daily dose enough? *Am J Psychiatry* 131:1027-1029, 1974.

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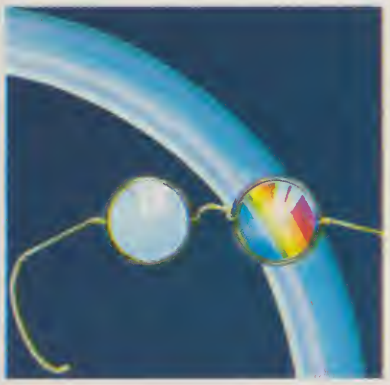
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Case report

Cystic dilatation of biliary tract: choledochal cyst

Victor C. Dy, M.D.
Lee S. Serfas, M.D.

Cystic dilatation of the biliary tract is a rare condition. The anatomy of choledochal cyst was first described by Vater in 1723,[1] and idiopathic cystic dilatation of the common bile duct was reported by Todd in 1817.[2] Douglas in 1852 was the first to give an accurate explanation of the symptomatology and pathological characteristics of this lesion.[3]

The location, degree, and type of dilatation may vary. Types of cystic dilatation of biliary tract include:[4] (1) choledochal cyst; (2) diverticulum of the common bile duct; (3) choledochocele; and (4) dilatation of hepatic duct with or without involvement of common bile duct (Caroli's disease).

Yotuyanagi[2] classified choledochal cyst into four types. Type 1 involves the common bile, cystic, and common hepatic ducts and therefore has two orifices at its upper end (cystic and common hepatic) and one orifice at the lower end (common bile duct). Type 2 involves the common bile duct, cystic, and both hepatic ducts and therefore has three orifices at the upper end (the cystic and both hepatics) and one orifice at the lower end. Type 3 involves common bile, cystic, common hepatic, and pancreatic ducts and therefore has two orifices at the upper end and two at the lower end. Type 4 involves only the common bile duct.

In a series of 49 cases reviewed by Yotuyanagi, 65.3 percent were Type 1, 22.4 percent Type 2, 6.1 percent Type 3, and 6.1 percent Type 4. The case reported belongs to Type 1, the most common of the four types.

Dr. Dy is a pediatric surgeon at Memorial Sloane-Kettering Cancer Center in New York. Dr. Serfas is director of surgery at Easton Hospital.

Case report

A 64-year-old white male was admitted to Easton Hospital via the emergency room with the chief complaint of severe right upper quadrant abdominal pain. The patient was a relatively poor historian but apparently had been having intermittent, vague, epigastric pain radiating to the right upper quadrant for several years. For two months prior to admission the pain had been increasing in severity and frequency but not enough to stimulate the patient to seek medical evaluation.

The day of admission the pain became so severe that the patient reported to the emergency room. Within 24 hours of admission the pain became colicky and was accompanied by three episodes of vomiting. The patient was unable to relate his attacks of pain to any dietary indiscretion. He had no specific food intolerances, and he denied hematemesis, melena, change in bowel habits, and was unaware of any jaundice.

The patient's past medical history revealed that he had a gastrectomy performed at another hospital seven years prior to this admission, allegedly for peptic ulcer disease. He also had a right inguinal hernioplasty. The postoperative course for both procedures was uneventful and without sequelae.

When the patient was counseled regarding our working diagnosis of biliary tract disease, he remembered that, many years ago, he had been informed that he had gallbladder disease. He could remember none of the details, and he stated that he could not remember any recommendations of surgery for this condition. No mention was made of gallbladder disease at the time of his gastrectomy.

Physical examination on admission revealed the following data: pulse 78, respirations 22, temperature normal, BP 120/80. Positive physical findings revealed a jaundiced sclera and slightly decreased thoracic excursion secondary to splinting from abdominal pain. There was guarding, marked tenderness and rebound tenderness in the right upper quadrant with moderate tenderness in the epigastrium. Bowel sounds were hyperactive. Rectal examination was normal.

Tests and procedures at the time of admission revealed the following: WBC of 9100 with 66 polys, 29 percent bands, 3 lymphocytes, and 2 monocytes with a hemoglobin of 15.4 and hematocrit of 46.3. The urinalysis, electrolytes, prothrombin time, chest x-ray, and EKG were all within normal limits. The admission serum amylase was 195 (normal less than 200), and the urinary amylase was 1150 (normal less than 500).

The patient smoked approximately one pack of cigarettes daily and admitted to a chronic history of heavy alcoholic intake. The admission diagnosis was biliary colic, possibly with pancreatitis. It was also felt at admission that marginal ulcer should be ruled out.

The patient was treated with sedation, intravenous fluids, demerol, and fasting. Within 12 hours he improved, although he still had some distress in the right upper quadrant. The admitting bilirubin level was reported as 10.4 mgm percent; within 24 hours it had dropped to 3.8, and by 48 hours it had dropped to 2.1.

In view of the clinical improvement within 12 hours of adn ission, we decided to continue conservative treatment and further evaluation. An IV cholangiogram, performed after the bilirubin had dropped to 2.1, revealed no visualization. An upper GI series



Figure 1. Operative cholangiogram showing radiolucent stone in the cyst.



Figure 2. Operative cholangiogram, through the gallbladder, showing gallbladder and choledochal cyst.



Figure 3. Open cyst reveals 4-cm stone.



Figure 4. Stone removed, showing connection to common bile duct lumen.

revealed that the patient had a high subtotal gastrectomy with a gastrojejunostomy and no evidence of marginal ulceration. The patient continued to improve and by the third hospital day was essentially asymptomatic, although he had a slight daily elevation of temperature.

On the sixth hospital day we discussed with the patient our tentative plan to discharge him and follow him as an outpatient with the recommendation that an oral cholecystogram be performed in 3 to 6 weeks. Daily abdominal examinations had not revealed a palpable gallbladder or mass in the right upper quadrant.

On the seventh hospital day the patient suddenly developed severe right upper quadrant abdominal pain. We were surprised to find a tender globular mass palpable, for the first time, in the right subcostal region. We interpreted it as representing a distended gallbladder. This was an unusual manifestation because a patient with chronic cholecystitis and cholelithiasis does not usually distend his fibrotic gallbladder within one hour of developing biliary colic. This episode occurred at noon.

At 5 p.m. the mass was still palpable, and his temperature was 39.3C (102.8F). Intravenous antibiotics were started and the patient was scheduled for surgery the following day. During the night the patient's pain decreased dramatically. At 7 a.m. the mass could not be palpated; the patient was afebrile and without pain.

Exploration was conducted through a right subcostal incision. The area of the gastrojejunostomy was normal to palpation. The general abdominal exploration revealed no abnormalities. The pancreas felt normal.

The gallbladder wall was thickened, slightly edematous, fibrotic, and contracted. No stones were palpable within the gallbladder, nor were any demonstrated in the gallbladder when the specimen was removed and opened. There was a cystic area, 7 to 8 cm in diameter, present in the porta hepatis with marked edema and vascular adhesions in the area of the cyst.

An operative cholangiogram was performed with 50 percent hypaque after inserting a catheter in the fundus of the gallbladder. The two films that were taken were difficult to interpret because of the size of the cyst which filled with dye from the gallbladder. It appeared that a large stone, approximately 4 cm in diameter, was present in the cyst (Figure 1).

We were certain at this time that we were dealing with a choledochal cyst.

The gallbladder was removed, starting at the fundus, until we definitely demonstrated the cystic duct emptying into the choledochal cyst. A Kocher maneuver was performed, and the external cyst wall was successfully dissected from the duodenal stump, the second portion of the duodenum, and the common hepatic duct.

A repeat cholangiogram was performed after removal of the gallbladder by injecting the dye directly into the cyst. The cyst distended in spite of its thickened fibrotic wall when the dye was injected and no dye passed through the common duct into the duodenum. This occurrence was difficult to evaluate accurately because of the size of the choledochal cyst and also because barium was still present in the colon from a previous upper GI series (Figure 2). The cyst was opened, and a 4-cm stone and multiple small stones were removed (Figure 3). The posterior wall of the cyst was made up of the posterior wall of what would normally be the common hepatic and common bile ducts and, when the cyst was examined from within, the common hepatic orifice was easily visualized proximally as was the common duct distally. Both orifices were irrigated and several small stones removed from the hepatic ducts and one 3-mm stone from the distal common duct (Figure 4).

A #5 Bakes dilator was easily passed distally into the duodenum with no feeling of resistance or abnormality. We decided that it would be inadvisable to attempt excision of this choledochal cyst with an end-to-end anastomosis of the common hepatic duct to the common bile duct in view of the amount of inflammatory reaction that had been encountered, secondary to the choledochal cyst and his previous gastrectomy. Illustrative of the amount of reaction present is an estimated blood loss of approximately 1,000 cc, all of which was secondary to oozing in the area of the dissection and none of which was lost because of transection of a major vessel.

We decided to perform a choledochocystoduodenostomy since the patient had a Billroth II gastrectomy, and the duodenum was therefore defunctionalized. The original cystostomy, through which the stones were removed and the exploration carried out, was therefore closed with #2-0 chromic catgut sutures. The dependent wall of the choledochal cyst was easily approximated to the second portion of the duodenum over a distance of approximately 4 cm with interrupted #4-0 black silk. A 3-cm choledochocystoduodenostomy was performed with an inner layer of chromic catgut, after which the anterior wall was reinforced with interrupted atraumatic #4-0 black silk.

Postoperative course was essentially uneventful. He was continued on antibiotics for a total of 8 days. The bilirubin, serum amylase, urinary amylase, and serum lipase were normal. The patient was not transfused in spite of the rather significant blood loss. His postoperative hemoglobin was 11.0 and hematocrit 33.5.

He was discharged from the hospital on the tenth postoperative day. His retention sutures were removed three weeks postoperatively. An IV cholangiogram performed six weeks postoperatively revealed no visible dye but pneumobilia clearly outlined the hepatic ducts.

Discussion

The etiology of the choledochal cyst is unknown. Yotuyanagi has an excellent review of the etiology and pathogenesis postulated by different authors. He classified the theories as: (1) acquired postnatally, secondary to obstruction by stone, trauma, or inflammatory process; and (2) congenital. No single theory can explain all cases of choledochal cyst.

The most widely accepted theory is Yotuyanagi's hypothesis that there is unequal proliferation of epithelial cells of the primitive choledochus during the solid embryonic stage. The inadequate proliferation of the epithelial cells could be multifocal and affect both intra- and extra-hepatic biliary systems.

Alonso-Lej *et al.*[5] similarly classified the etiology into extrinsic (or acquired) and congenital. Babbitt and associates[6] in 1973 suggested that an anomalous relationship between the common bile duct and the pancreatic ducts allows reflux of pancreatic juice into the common bile duct. This eventually leads to cholangitis and dilatation of the common bile duct.

Glenn and McSherry[7] proposed that congenital segmental absence of the subserous layer in the biliary tract serves as a weak point for cystic dilatation, which becomes more pronounced in the presence of distal obstruction. Choledochal cyst associated with atresia or stenosis of the distal common bile duct is classified by Kasia as Type 1 biliary atresia.[8]

The incidence of this disease ranges from 1 in 13,000 to 1 in 260,000 hospital admissions.[9] According to Tsuchiya and associates,[10] at least 965 cases have been reported. Review of our medical records from 1966 to 1976 revealed a total of 114,166 hospital discharges and 2,179 cases of cholecystectomy where biliary tract surgery was performed. One case of congenital absence of the gallbladder and no prior cases of choledochal cyst were recorded. Our incidence of choledochal cyst has been 1 in 2,179 cases of biliary tract surgery and 1 in 114,166 hospital discharges.

Since about one-third of reported cases have been made by the Japanese, one must suspect a racial predisposition. Choledochal cyst may be found at any age. Lee, Min, and associates[11] in their reviews reported that 54 of 97 cases (55.7 percent) were found at age 10 and below, and Alonzo-Lej gave a figure of 45 percent of cases found below age 10. Flanigan[12] in 1975 reported 81 percent of patients were females and 61 percent were discovered before age 10.

Diagnosis

In 30 percent of the 94 cases analyzed by Alonzo-Lej *et al.* diagnosis was made or considered preoperatively. The presence of pain, jaundice, and a palpable mass constitute the classic triad. Lorenzo *et al.* reported that the triad is present in approximately two-thirds of patients; Yue, 22 percent of patients. Tsardakos and Robnett[13] reported the triad was present in 57.7 percent, pain present in 63.4 percent, jaundice in 69 percent, and a palpable mass in 72 percent.

Roentgenologic studies might be helpful in establishing the diagnosis preoperatively. Flat films of the abdomen may reveal a mass displacing

the stomach and colon. Upper GI series, barium enema, or IVP may help to outline the mass and differentiate it from other conditions. IV cholangiogram has been recommended by Serfas and Lyter[14] when the serum bilirubin is less than 3 mg percent.

Cholangitis, as signified by fever, leucocytosis, and accentuation of signs and symptoms, may develop. Stones in the gallbladder and/or biliary tract have been reported in association with some choledochal cysts. Maingot, however, reported stones present in less than 1 percent, and thus stones are not of primary concern in the etiology, symptomatology, or treatment of choledochal cyst. In the many cases reported without stones, the triad of pain, jaundice, and a palpable mass is apparently secondary to intermittent obstruction of the outlet of the cyst due to redundancy of the cyst wall itself which can act as a ball-valve mechanism.

Our case revealed multiple stones in the cyst with the largest one measuring 4 cm in diameter. The fluctuation of the serum bilirubin level preoperatively suggests the stones caused intermittent obstruction. The triad of pain, jaundice, and a palpable mass was present for only a few hours when a mass was palpable in the right upper quadrant, suggesting the cyst was distended secondary to a stone blocking the bile passage. When the stone dislodged and allowed drainage of bile, the mass disappeared.

There is great variation in size of the cysts. As much as 4 to 5 liters of bile in the cyst has been reported. Reed and Burrell reported 8 liters of bile obtained in one patient, though Poate doubts the authenticity of this case.[15]

Aspiration of the cyst has been reported by Kjellberg and Lumpkin *et al.* with injection of radio-opaque material as a preoperative diagnostic test without complications. This technique is not recommended because of the danger of producing bile peritonitis. Arteriogram and scanning of the pancreas may be of value in ruling out other conditions. Perhaps with recent advancement of ultrasonography, diagnosis may be more accurately made preoperatively. To our knowledge, no report has yet been made of the use of ultrasound as a diagnostic aid.

Treatment

Choledochal cyst should be treated surgically. Flanigan has stated untreated or medically treated patients had a 97 percent mortality. The operative mortality has decreased from 83 percent to 3 to 4 percent.

Operative cholangiogram is definitely indicated in order to visualize the entire biliary system. External drainage should be reserved as a temporary measure for decompression in severely ill patients who represent prohibitive risks for a definitive procedure.

Choledochocystogastrostomy is rarely performed today because some authors believe that cholangitis could be produced by reflux of gastric and duodenal chyme which subsequently leads to stenosis of the anastomosis. Choledochocystoduodenostomy is technically the easiest method of drainage, and it involves minimal dissection. A 2- to 3-cm anastomosis stoma has been recommended by Duckett *et al.*[16]

Roux-en-Y choledochocystojejunostomy has been recommended by several authors. The length of the Roux-en-Y loop should be about 30 cm to assure satisfactory drainage and avoid reflux of intestinal content to the biliary system. Ascending cholangitis will not be a problem if an adequate anastomosis is made. Walters[17] reviewed 186 cases of stricture of the common and hepatic bile ducts and concluded that, following choledochoduodenostomy, cholangitis is not secondary to reflux of gastrointestinal content but is secondary to stenosis of the anastomosis. Braasch[18] and Donaldson[19] have made the same observation.

Side-to-side choledochocystojejunostomy and side-to-side jeju-jejunostomy may be performed. The jeju-jejunostomy shunts the gastric and intestinal chyme away from the biliary system. The cyst should be anastomosed at the most dependent portion to ensure satisfactory drainage.

Kasai and associates[20] emphasized the increased incidence of carcinoma arising in the choledochal cyst and have recommended primary excision of the cyst. The incidence of biliary carcinoma in choledochal cyst is approximately 20 times greater than the incidence of bile duct carcinoma in the general population. Tsuchiya reported 4 of 17 patients with associated biliary carcinoma.

Several hypotheses have been postulated regarding malignant changes in a choledochal cyst. Irwin and Morison suggest that the irritation of the stagnant bile within the cyst causes squamous metaplasia followed by malignant changes. George and Maingot noticed the close chemical relationship between certain bile acids and methylcholanthrene, a known carcinogen. Fischer proposed that chronic inflammation in the cyst provokes repeated regeneration of the cyst lining and eventually may lead to malignant changes. Excision was suggested as early as 1924 by McWhorter. Kasai in his article in 1970 recommended excision of the cyst with Roux-en-Y hepaticojejunostomy.

Recommendation

Our recommendation for treatment is the performance of internal dependent drainage by cystoduodenostomy or drainage to a defunctionalized portion of bowel with an anastomosis 3 to 5 cm in length. The inside of the cyst should be examined and any suspicious areas biopsied. If frozen sections reveal carcinoma, the cyst should be excised and drained. Excision of the cyst is a difficult operation, and we discourage using it routinely as a prophylactic measure against the possible future development of carcinoma.

Summary

The case of a 64-year-old man with a choledochal cyst has been presented. Although the condition is certainly not common, more than 900 cases have been reported. Abdominal surgeons should be familiar with the condition, recognize it if encountered at the time of surgery, and be familiar with the treatment options.

The patient demonstrated the triad of abdominal pain, jaundice, and palpable mass for less than 12 hours during the course of his disease. In spite of the multiple stones present in the

choledochal cyst, biliary drainage was apparently not interfered with for many years except for very short and intermittent periods of time, allowing the patient to live in relative comfort.

Fortunately the patient was under observation when the outlet from the choledochal cyst obviously became obstructed, either from a ball-valve mechanism or, more likely, from a gallstone. The resulting acute pain and temporary dilatation of the cyst, in spite of its fibrotic wall and surrounding reaction, to the point at which it became palpable, completed the elements of the classically described triad. The stone became dislodged spontaneously; the cyst decompressed; the pain disappeared; and the palpable mass was no longer demonstrable. □

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in my opinion

Do big health insurance carriers play fair with payouts?

Henry F. Lee, M.D.

Do you feel that Blue Shield and other health and accident carriers "brush off" your complaints about payments or other matters? This article suggests you're getting a better break than you think . . .

Do Blue Shield, Blue Cross, and other carriers cut the patient or the doctor short? Are they giving less than money's worth? Does the private practice of medicine have any input in the decisions?

I have done my share of complaining in the past about these problems, but my point of view has changed. Experience has led me to see the good in our health insurance industry. What gives me the right to comment? My experiences during twenty years in a group pediatric practice; staff appointments in urban and suburban hospitals; and part-time teaching in one of our medical schools qualify me.

Most of us want health insurance for ourselves and our patients, but many physicians believe that they and their patients have been short-changed. Most of these beliefs are based on unrealistic expectations or simple misunderstandings.

For seventeen years I have devoted time to contested claims review in the pediatric area; I have also served on a variety of insurance-related committees. It has been my experience that insurance carriers, subscriber-patients, and physicians form a triangle; each is important and each needs the other. When they need a mediator who understands the contract, the special problems of doctors, the vagaries of disease, and the patients' points of view, I stand in the middle and try to see that each side is treated fairly.

Gradually I have become less critical of our health and accident insurance system. In all these years I have yet to see any company, profit or non-profit, try to give any patient or doctor less than his full entitlement under the contract that applies. I believe it's a less arbitrary system than any government bureaucracy that can be imagined; that it's basically a flexible system; and that, by and large, patient and doctor alike get fair treatment.

For any given premium structure only so much can be paid out. Large non-profit organizations like Blue Cross and Blue Shield return 90 percent or more of premium income to policyholders. In general, they cannot make significant changes in premium or policy structure without approval of state insurance offices.

In the early 1960s, one of the largest Blue Cross plans tried something new by establishing a physicians review board consisting of doctors from all major specialties. Its purpose was to be the mediator when differences arose between patients, hospitals, physicians, and Blue Cross. The board examined the records and attempted to reach decisions fair to all parties. Many types of dispute were studied. Most often Blue Cross personnel had made correct decisions. Occasionally the board ruled in favor of the patient or hospital. In these situations, it was usually because insurance personnel, going by the rules, did not understand the medical nuances of a case. In a majority of cases, the board was reasonably successful as an arbitrator.

Dr. Lee is a pediatrician practicing in Philadelphia.

About 1963 the Philadelphia County Medical Society established an Insurance Mediation Committee. Its purpose was to arbitrate complaints about physicians fees or insurance matters involving commercial carriers. Members were volunteers with considerable practice experience. Representatives of the large health and accident carriers active in the area soon were attending committee deliberations. They presented cases for arbitration, always urging the committee to give the policyholder every break possible under his contract. The committee and a similar one in California were the first of their kind; the insurance industry watched their performances closely.

From these beginnings, Pennsylvania Blue Shield and other carriers established the use of medical advisors. Physicians are now assured that any significant dispute they may have will be heard and evaluated by their peers. As one of Pennsylvania Blue Shield's medical advisors, I have a straightforward assignment to help resolve problems involving policyholders, physicians, and abrogation of rules.

The processing of claims by insurers at the rate of more than 30,000 a day is a complex but streamlined process. Most are processed and paid by full-time personnel; only a small fraction are reviewed by medical advisors.

Most insurers generally follow the same claims processing procedures. Claims without sufficient or appropriate information to allow machine processing are pulled out of the system for manual review. At this point the

claim goes to a specially trained claims examiner. When medical review is necessary, the claim is sent to a medical review section where a registered nurse with extensive experience in health insurance claims processing reviews the claim. The R.N. can decide to pay the claim, but cannot reduce or deny payment. When an immediate decision is questionable, more information is obtained and, if necessary, the claim proceeds to the next level of review, a medical director.

A medical director reviews all the data and may then pay, reject, or reduce the claim. The patient receives a detailed explanation of the decision. His contract controls the maximum permissible payment which can be approved.

When physicians are dissatisfied with payment, they may write to most insurers and present their reasons and any supporting information. The claim will be reviewed again and, if there is any doubt about medical aspects, it will be sent to one of the medical advisors. An advisor then submits a written recommendation to the insurer. Most insurers act promptly on the advisor's recommendation.

A doctor should remember that if his fees are significantly higher than those of other doctors in this area the carrier cannot pay charges in full under a contract specifying "usual and reasonable."

Occasionally fraudulent claims are received but computer analysis has reduced the likelihood that these will be paid. Computers spot irregularities and any claims suggestive of cheating are immediately processed through a meticulous channel of review.

It is inevitable in large insurance operations that an occasional inequity will occur. In most systems when such a situation is discovered, a reporting letter will be carefully considered by experienced colleagues. Not all insurers operate in the same manner nor do all carriers follow a single, consistent set of rules. But all will listen to reasonable complaints and make an honest effort to correct them.

The only visible alternatives to the big health insurance carriers are government administered plans that will, at best, be far less flexible. And at worst—haven't we already had a taste? □

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Medical judgment and malpractice

Courts expect 'reasonable' action from physicians

Jerry Zaslow, M.D., J.D., F.C.L.M.

In order for a plaintiff to prevail in an action based on negligence, he must satisfy four criteria: that a legal duty was owed to him by the defendant; that there was a breach of that duty; that there was harm; and, finally, that the breach was the proximate (legal) cause of the harm. In a case of negligence in the medical field, the duty owed to the plaintiff is that he is rendered that level of care as established by physicians practicing the same type of medicine in his community (or in similar communities or generally, depending on jurisdiction) and that the physician act as a reasonable man under the circumstances of the case.

Obviously, the best defense a physician can offer is to prove that he did, in fact, follow the standard of care of his peers. There are many cases, however, in which the only defense the physician offers is that he used his best medical judgment in treating his patient.

The courts in all jurisdictions have recognized that the practice of medicine is not an exact science; in many ways it is more art than science. Judgment plays a large part in the diagnosis and treatment of diseases, and judgment decisions constantly are being made. In view of this, the general rule promulgated by the courts has been that a physician is not liable for an error in judgment provided he has availed himself of the advances in the medical field available to him.

The courts have not detailed what those advances might be, and there should be no need for them to do so. The modalities available vary with each case, and it is for the medical, not the legal, profession to know what these are. The basic tenet is that the physician must keep abreast of changes in medical practice. Failing to do so and falling behind in the continuing advances is an injustice to the patient to whom the physician willingly chose to dedicate his time and efforts.

In addition to keeping abreast of advances and changes in medicine, the physician must use that judgment in diagnosis and treatment which a reasonable man in the circumstances of the case would use. While not all physicians will manage any particular case in a particular way, it may be expected that the basis for the decision of how to act will be founded on principles of care that are accepted by at least a respectable minority of his peers.

The physician must realize that, because he has done something in a certain way, his judgment will not automatically exculpate him from liability should an untoward result follow. The physician must abandon attitudes that often have prevailed in the past: that he can do no wrong, that he need account to no one for his medical decision, that his judgment is not to be questioned by anyone, and that an untoward result was an "act of God," and one of the unfortunate complications or risks of a particular procedure. While the latter is often true, the judgment can be proper only when he acts as a "reasonable" man under the circumstances of the case, availing himself of both his past experience and advances in medicine applicable to the situation.

The resident staff in many institutions with ongoing training programs undertake, more or less independently, the care of the patient. While the attending staff is available, frequently there is a lack of adequate supervision of choice of management in diagnostic and therapeutic areas. The probability of errors in judgment is generally proportionate to the experience and training of the physician, with a greater likelihood of error when a resident-in-training makes all the decisions.

The attending staff must have control over all acts of the resident. This is a duty owed to the patient and an obligation owed to the resident staff. The attitude that the physician-in-training will learn by his mistakes should never be adopted. Rather, the attitude should be that the resident should learn from mistakes made by those with more experience, by learning and seeing what should and should not be done.

Recently the medical profession has been made more accountable for the type of care it renders. While this may place a heavier burden on the physician, he is able to adjust to this demand because the medical profession has been trained with only one purpose in mind: to render the best care available to the patient. This can only be done if the physician listens to the patient's complaints; does complete physical examinations; discusses fully with the patient the modalities to be emphasized; keeps abreast of the advances in medicine; keeps the patient's interest foremost in all decisions, weighing risks against benefits; and accepts the fact that medical negligence does exist, and that he must act "reasonably" in efforts in the patient's behalf to keep negligence to a minimum. □

Dr. Zaslow is a surgeon in private practice in Philadelphia and a practicing attorney.



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MDs in the news

The following physicians recently were elected officers of the Philadelphia Laryngological Society: **Ernest L. McKenna, Jr., MD,** president; **Charles L. Rojer, MD,** secretary; and **Louis W. Welsh, MD,** treasurer.

Peter Safar, MD, internationally known pioneer in critical care medicine and cardiopulmonary resuscitation, has been appointed Distinguished Service Professor at the University of Pittsburgh in conjunction with his resignation as chairman of anesthesiology/critical care medicine in the School of Medicine. Succeeding Dr. Safar in that capacity is **Ryan Cook, MD,** associate professor of clinical anesthesiology.

Elected as new officers of the Pittsburgh Academy of Medicine are: **Robert B. Atwell, MD,** president; **William M. Cooper, MD,** president elect; **Dorothy C. Scott, MD,** secretary; **Stuart E. Price, Jr., MD,** treasurer; and **H. Lee Dameshek, MD,** assistant treasurer.

Paul L. McLain, MD, recently received the Philip K. Hench Distinguished Alumnus Award from the Medical Alumni Association of the University of Pittsburgh School of Medicine. The award honors the memory of Nobel Laureate in Medicine Dr. Philip K. Hench, graduate of Pitt's medical school, and is presented to an individual who has made outstanding contributions to the school and the medical profession.

The following physicians recently were elected officers of the Medical Alumni Association of the University of Pittsburgh School of Medicine: **Phillip R. Levine, MD,** president; **Lawrence D. Ellis, MD,** president elect; **Dorothy C. Scott, MD,** vice president; **Mark E. Thompson, MD,** secretary; and **Richard H. Horn, MD,** treasurer.

Newly elected officers of the Pittsburgh Psychiatric Society are: **Marjorie TaVoularis, MD,** president; **Robert H. Stanger, MD,** vice president; **Ruth Coyne, MD,** secretary; and **Robert Trivus, MD,** treasurer.

Monto Ho, MD, has been named one of 25 faculty scholars in North America by the Josiah Macy, Jr. Foundation. Dr. Ho will pursue his research in viral immunology as a visiting fellow at the John Curtin School of Medical Research in Canberra, Australia.

Recently elected officers of the Schuylkill County Medical Society are: **John Y. Modarress, MD,** president; **Louis Gabriel, MD,** president elect; **Richard Bindie, MD,** secretary; and **Michael Pristas, MD,** treasurer.

John C. Gaisford, MD, Pittsburgh, chairman of surgery and director of the Western Pennsylvania Hospital's burn center, recently was elected 1978-79 president of the Society of Head and Neck Surgeons.

Gerald H. Escovitz, MD, associate dean for medical education at the Medical College of Pennsylvania, has been awarded a Senior International Fellowship of the Fogarty International Center for Advanced Study in the Health Sciences. He will work at Israel's Hebrew University Hadassah Medical Center in a program to enhance that country's evaluation of continuing education for physicians.

The Pittsburgh Obstetrical and Gynecological Society recently elected the following physicians to serve as officers in 1978-79: **Frank Reda, MD,** president; **John E. Walker, MD,** vice president; **Robert E. Warner, MD,** secretary; and **Robert P. Gannon, MD,** treasurer.

Leslie Nicholas, MD, was the only American elected a technical counsellor at the recent meeting of the International Union Against the Venereal Diseases and the Treponematoses held in Leeds, England. Dr. Nicholas is professor of medicine at Hahnemann Medical College and Hospital and president of the American Venereal Disease Association.

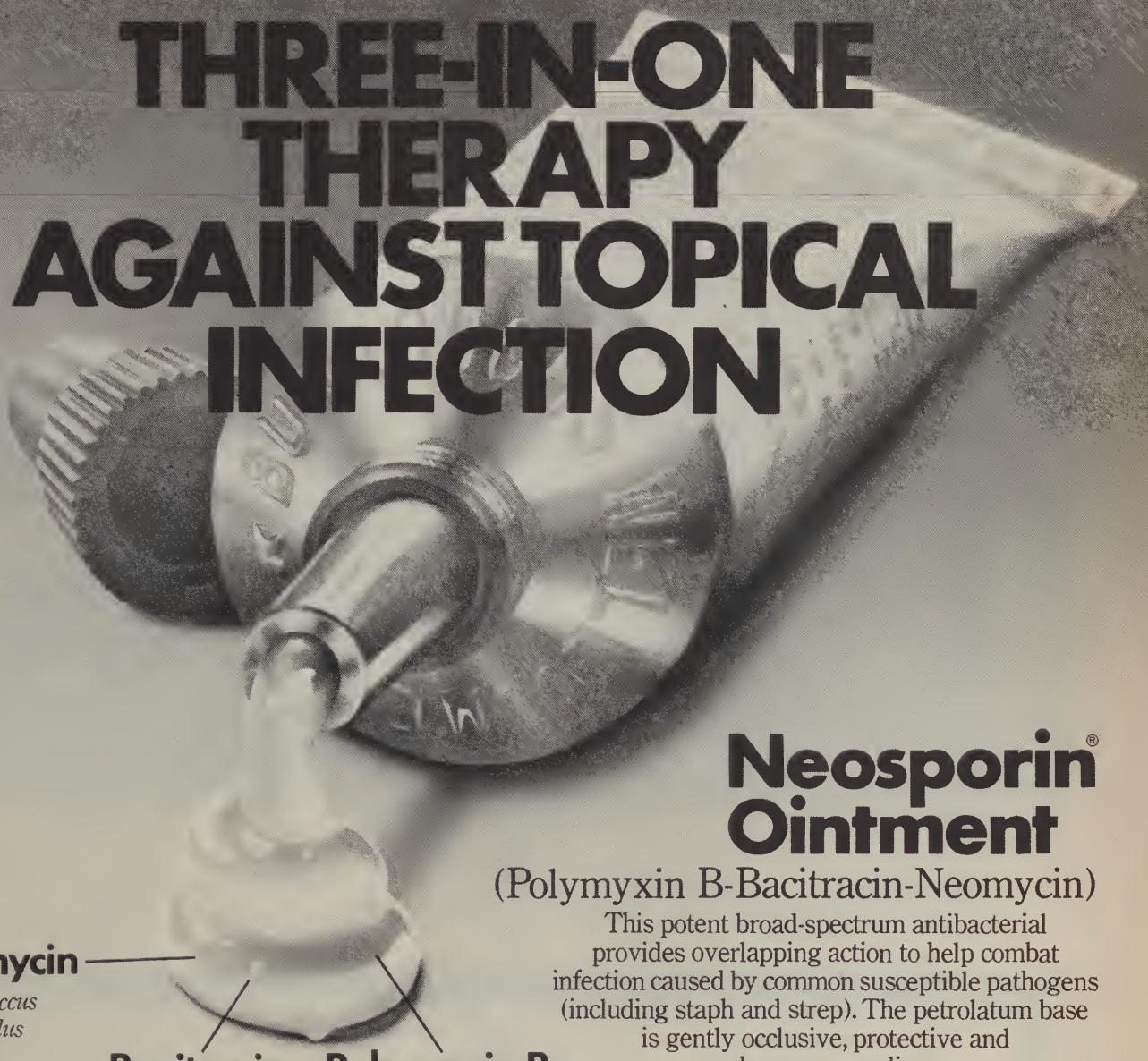
Ray A. Moyer, MD, has been named director of Temple University Hospital's sports medicine center. Dr. Moyer succeeds Theodore C. Quedenfeld in the position.

Martin Rubel, MD, has been named director of the adolescent treatment program at the Institute of Pennsylvania Hospital. Since 1971 Dr. Rubel has been clinical assistant professor of psychiatry at Temple University School of Medicine and recently was appointed to the faculty of the Philadelphia Psychoanalytic Institute.

Cyril H. Wecht, MD, Allegheny County coroner, recently was awarded the Distinguished Service to Law Enforcement Award by the Pennsylvania State Division of the International Association of Identification Officers. Dr. Wecht, a forensic pathologist and attorney, is a faculty member at the University of Pittsburgh and Duquesne University and is past president of the American Academy of Forensic Sciences and the American College of Legal Medicine.

Two Pennsylvania physicians recently received certificates for continuing education in utilization review. They are: **John G. Hallisey, MD,** chief of utilization review at Aliquippa Hospital, and **Joan M. Roberts, MD,** chairman of utilization review at Chestnut Hill Hospital, Philadelphia.

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Please respond to

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4th Annual Emergency Medicine Seminar
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9 a.m. to 5 p.m. Tuition $40

Clinical Update in Gynecology
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Ophthalmology Update for Family Physicians
Wednesday, November 1, 1978
1 p.m. to 5 p.m. Tuition: $25

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1 p.m. to 5 p.m. Tuition: $25

Advances in Clinical Practice - 1979*
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9 a.m. to 5 p.m. Tuition $105

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Wednesday March 7, 1979
9 a.m. to 5 p.m. Tuition: $40

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9 a.m. to 5 p.m. Tuition: $40

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Wednesday, April 4, 1979
9 a.m. to 5 p.m. Tuition: $40

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Wednesday, April 18, 1979
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As an organization accredited for continuing medical education, the Geisinger Medical Center certifies that these activities meet the criteria for credit hours in Category I of the Physician's Recognition Award of the American Medical Association. (Refer to each program — full day - 7 hours credit and ½ day - 4 hours credit).

For further information write to:
Millie K. Fleetwood, Ph.D.
Geisinger Medical Center
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or telephone (717) 275-6333

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Psychiatrist—Board certified or board eligible. Mental hospital in metropolitan area. Easy access to New York, Philadelphia, and close to Pocono resort area. Good salary with excellent fringe and retirement benefits. Residence available. Pennsylvania license required. Contact Henry Buxbaum, M.D., Superintendent, Clarks Summit State Hospital, Clarks Summit, PA 18411; (717) 586-2011.

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CONTINUING EDUCATION

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DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy*, Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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Additional indications: Replacement therapy. When androgen deficiency is the cause of: male climacteric/eunuchoidism, eunuchism/post-puberal cryptorchidism.



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obituaries

• Indicates membership in the Pennsylvania Society at time of death.

• **Charles R. Fox,** Topton; Jefferson Medical College, 1918; age 86; died May 20, 1978. Dr. Fox, who had practiced in the Northampton area for 51 years, was a past president of the Lehigh County Medical Society and a former mayor of Northampton.

• **Robert F. Hechler,** Shickshinny; Hahnemann Medical College, 1943; page 61; died May 13, 1978.

• **Herbert H. Herskovitz,** Haverford; Temple University School of Medicine, 1931; age 74; died April 11, 1978.

• **James B. Landis,** Sweet Home, Oregon; Hahnemann Medical College, 1951; age 53; died April 5, 1978. He had been medical director of Smith Kline & French Laboratories in Philadelphia and was most recently chief medical consultant for the Oregon state public welfare division.

• **E. James Morrissey,** Wyomissing; Harvard Medical School, 1932; page 72; died May 21, 1978. He had been chief of orthopedics at Reading Hospital from 1948 to 1970. In 1959 Dr. Morrissey was the first surgeon in the United States to replace a severed limb.

• **Nathan M. Nobel,** Philadelphia; Jefferson Medical College, 1931; age 71; died April, 1978.

• **Frederick W. Ort,** Coopersburg; Temple University School of Medicine, 1937; page 76; died April 28, 1978.

• **Robert C. Stewart,** Willow Grove; University of Pittsburgh School of Medicine, 1930; age 75; died April 13, 1978.

• **James Weres,** Whitehall; Jefferson Medical College, 1932; age 71; died May 6, 1978. He was a past president of the Warren County Medical Society and had practiced medicine in the Coplay area for 27 years.

John S. Newkam, Jr., Carlisle; University of Pittsburgh School of Medicine, 1949; age 54; died May 20, 1978.

• **Charles M. Pohl,** White Haven; Hahnemann Medical College, 1934; page 71; died April 3, 1978.

Harlow B. Rowell, York Beach, Maine; University of Pennsylvania School of Medicine, 1934; age 69; died March 11, 1978.

• **Harry Rubin,** Philadelphia; Jefferson Medical College, 1924; age 79; died May 19, 1978. He had been a general practitioner in Philadelphia for 54 years.

• **Albert Behrend,** Boca Raton, Florida; University of Pennsylvania School of Medicine, 1932; age 70; died July 23, 1978. Dr. Behrend was senior attending surgeon at Albert Einstein Medical Center, Northern Division, from 1941 until he moved to Florida in 1972.

• **Harold H. Cashman,** Pittsburgh; Temple University School of Medicine, 1943; age 59; died June 17, 1978.

• **Harvey D. Groff,** New Brunswick, New Jersey; Jefferson Medical College, 1943; age 61; died June 21, 1978.

• **William A. Guenon,** Greencastle; University of Pennsylvania School of Medicine, 1935; age 68; died July 1, 1978. Dr. Guenon, who had practiced general medicine in Greencastle for 40 years, was a member and past president of the Waynesboro Hospital staff and the Franklin County Medical Society.

• **Paul D. Harrison,** Union City; Western Reserve University School of Medicine, 1929; age 74; died August 1, 1978.

• **Arthur A. Hartley,** Cherry Hill, New Jersey; Hahnemann Medical College, 1934; age 70; died June 3, 1978.

• **Joseph R. Kielar,** Simpson; Jefferson Medical College, 1920; age 71; died July 10, 1978. He had practiced medicine in the upper Lackawanna valley for 57 years.

• **Harvey Klaer, Jr.,** Milford; University of Pennsylvania School of Medicine, 1931; age 71; died June 14, 1978. He had practiced general medicine in Milford for 30 years.

• **Frederick H. Leavitt,** Merion Station; University of Pennsylvania School of Medicine, 1911; age 90; died June 6, 1978. He had practiced psychiatry for 57 years.

• **Edward Lebovitz,** Pittsburgh; Jefferson Medical College, 1923; age 79; died July 9, 1978. He was a charter member of the College of Chest Physicians and was a pioneer in the care of tuberculosis patients in Pittsburgh.

• **Virgil A. LoRusso,** Erie; George Washington University School of Medicine, 1941; age 65; died August 9, 1978.

• **Robert M. Lukens,** Wildwood Crest, New Jersey; Jefferson Medical College, 1912; age 90; died June 24, 1978. Dr. Lukens, an otolaryngologist, was a member of the Jefferson Medical College faculty from 1914 until his retirement in 1961 after 50 years of practice.

• **William J. Reddy,** Johnstown; Medico-Chirurgical College of Philadelphia, 1915; age 88; died July 29, 1978. He had been chief of surgery at Mercy Hospital, Johnstown, and had served on the board of directors of the Cambria County Medical Society from 1946 to 1948.

• **Stephen A. Schlesinger,** Monroeville; Johns Hopkins University School of Medicine, 1968; age 35; died July 3, 1978.

• **William D. Schrack, Jr.,** Etters; University of Pennsylvania School of Medicine, 1935; age 69; died June 23, 1978. Dr. Schrack was a retired director of the Division of Communicable Disease Control of the state Department of Health.

• **James E. Townsend,** Murrysville; University of Pittsburgh School of Medicine, 1944; age 57; died July 18, 1978. He had practiced in Murrysville since 1948 and was on the staff of the East Suburban Health Center.

• **Thomas J. Vischer,** Flourtown; Hahnemann Medical College, 1924; age 78; died August 5, 1978. He had been an associate professor at Hahnemann for 30 years and in 1975 was honored by the State Society for 50 years of service to the medical profession.

• **Irving J. Wolman,** Melrose Park; Johns Hopkins University School of Medicine, 1929; age 72; died June 1978. Until his retirement in 1970, Dr. Wolman had been director of laboratories and of the division of hematology at Children's Hospital of Philadelphia.

Joseph V. DiPrimio, Pittsburgh; Georgetown University School of Medicine, 1955; age 53; died April 2, 1978.

Edward E. Roth, Phoenix, Arizona; St. Louis University School of Medicine, 1933; age 70; died January 23, 1978. He had practiced medicine in Donora for 33 years.

Before prescribing, please consult complete product information, a summary of which follows:

The effectiveness of Valium (diazepam) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindications: Tablets in children under 6 months of age; known hypersensitivity; acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: As with most CNS-acting drugs, caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Withdrawal symptoms (similar to those with barbiturates, alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal/muscle cramps, vomiting, sweating). Keep addiction-prone individuals (drug addicts or alcoholics) under careful surveillance because of predisposition to habituation/dependence.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations, as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

ORAL: Advise patients against simultaneous ingestion of alcohol and other CNS depressants.

Not of value in treatment of psychotic patients; should not be employed in lieu of appropriate treatment. When using oral form adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increase in dosage of standard anticonvulsant medication; abrupt withdrawal in such cases may be associated with temporary increase in frequency and/or severity of seizures.

INJECTABLE: *To reduce the possibility of venous thrombosis, phlebitis, local irritation, swelling, and, rarely, vascular impairment when used I.V.: inject slowly, taking at least one minute for each 5 mg (1 ml) given; do not use small veins, i.e., dorsum of hand or wrist; use extreme care to avoid intra-arterial administration or extravasation. Do not mix or dilute Valium with other solutions or drugs in syringe or infusion flask. If it is not feasible to administer Valium directly I.V., it may be injected slowly through the infusion tubing as close as possible to the vein insertion.*

Administer with extreme care to elderly, very ill, those with limited pulmonary reserve because of possibility of apnea and/or cardiac arrest; concomitant use of barbiturates, alcohol or other CNS depressants increases depression with increased risk of apnea; have resuscitative facilities available. When used with narcotic analgesic eliminate or reduce narcotic dosage at least 1/3, administer in small increments. Should not be administered to patients in shock, coma, acute alcoholic intoxication with depression of vital signs.

Has precipitated tonic status epilepticus in patients treated for petit mal status or petit mal variant status.

Withdrawal symptoms (similar to those with barbiturates, alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal/muscle cramps, vomiting, sweating). Keep addiction-prone individuals under careful surveillance because of predisposition to habituation/dependence. Not recommended for OB use.

Efficacy/safety not established in neonates (age 30 days or less); prolonged CNS depression observed. In children, give slowly (up to 0.25 mg/kg over 3 minutes) to avoid apnea or prolonged somnolence; can be repeated after 15 to 30 minutes. If no relief after third administration, appropriate adjunctive therapy is recommended.

Precautions: If combined with other psychotropics or anticonvulsants, carefully consider individual pharmacologic effects—particularly with known compounds which may potentiate action of Valium (diazepam), *i.e.*, phenothiazines, narcotics, barbiturates, MAO inhibitors and antidepressants. Protective measures indicated in highly anxious patients with accompanying depression who may have suicidal tendencies. Observe usual precautions in impaired hepatic function; avoid accumulation in patients with compromised kidney function. Limit oral dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation (initially 2 to 2½ mg once or twice daily, increasing gradually as needed or tolerated).

INJECTABLE: Although promptly controlled, seizures may return; readminister if necessary; not recommended for long-term maintenance therapy. Laryngospasm/increased cough reflex are possible during peroral endoscopic procedures; use topical anesthetic, have necessary countermeasures available. Hypotension or muscular weakness possible, particularly when used with narcotics, barbiturates or alcohol. Use lower doses (2 to 5 mg) for elderly/debilitated.

Adverse Reactions: Side effects most commonly reported were drowsiness, fatigue, ataxia. Infrequently encountered were confusion, constipation, depression, diplopia, dysarthria, headache, hypotension, incontinence, jaundice, changes in libido, nausea, changes in salivation, skin rash, slurred speech, tremor, urinary retention, vertigo, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances and stimulation have been reported; should these occur, discontinue drug.

Because of isolated reports of neutropenia and jaundice, periodic blood counts, liver function tests advisable during long-term therapy. Minor changes in EEG patterns, usually low-voltage fast activity, have been observed in patients during and after Valium (diazepam) therapy and are of no known significance.

INJECTABLE: Venous thrombosis/phlebitis at injection site, hypoactivity, syncope, bradycardia, cardiovascular collapse, nystagmus, urticaria, hiccups, neutropenia.

In peroral endoscopic procedures, coughing, depressed respiration, dyspnea, hyperventilation, laryngospasm/pain in throat or chest have been reported.

Management of Overdosage: Manifestations include somnolence, confusion, coma, diminished reflexes. Monitor respiration, pulse, blood pressure; employ general supportive measures, I.V. fluids, adequate airway. Use levarterenol or metaraminol for hypotension, caffeine and sodium benzoate for CNS-depressive effects. Dialysis is of limited value.

Supplied: Tablets, 2 mg, 5 mg and 10 mg, bottles of 100 and 500; Tel-E-Dose® (unit dose) packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available singly and in trays of 10. Ampuls, 2 ml, boxes of 10; Vials, 10 ml, boxes of 1; Tel-E-Ject® (disposable syringes), 2 ml, boxes of 10. Each ml contains 5 mg diazepam, compounded with 40% propylene glycol, 10% ethyl alcohol, 5% sodium benzoate and benzoic acid as buffers, and 1.5% benzyl alcohol as preservative.

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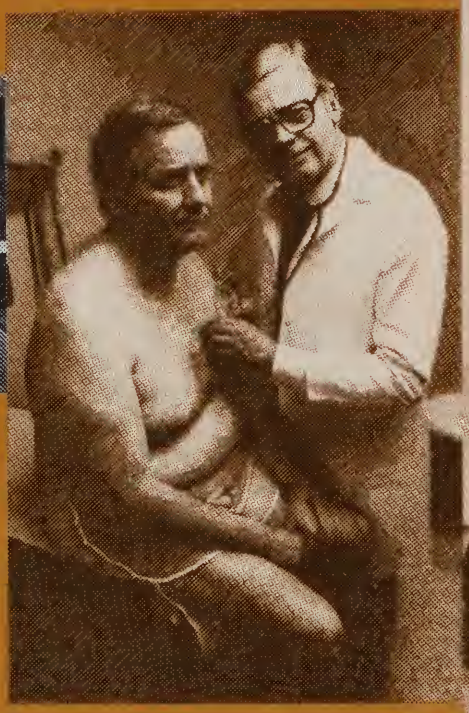
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synonymous with relief of anxiety

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Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states. Efficacy beyond four months not established by systematic clinical studies. Periodic reassessment of therapy recommended.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Warn patients that mental and/or physical abilities required for tasks such as driving or operating machinery may be impaired, as may be mental alertness in children, and that concomitant use with alcohol or CNS depressants may have an additive effect. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral–Adults:* Mild and moderate anxiety and tension, 5 or 10 mg *t.i.d.* or *q.i.d.*; severe states, 20 or 25 mg *t.i.d.* or *q.i.d. Geriatric patients:* 5 mg *b.i.d.* to *q.i.d.* (See Precautions.)

Supplied: Librium® (chlordiazepoxide HCl) *Capsules*, 5 mg, 10 mg and 25 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available singly and in trays of 10. Libritabs® (chlordiazepoxide) *Tablets*, 5 mg, 10 mg and 25 mg—bottles of 100 and 500. With respect to clinical activity, capsules and tablets are indistinguishable.

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PMS HOUSE OF DELEGATES TACKLES VARIETY OF ISSUES

The Society's House of Delegates, in session at the Host Farm Resort Motel, Lancaster, is acting on over 30 resolutions and a number of recommendations from officers and councils. The role of the physician in malpractice risk management, health care cost containment measures, an AMA membership campaign, minimum standards for mental health services, and the relationship of physicians with other health care practitioners--all will be considered during three days of meetings. John B. Lovette, MD, will be installed as president of the Society. Delegates will review all Society activities since the last meeting of the House, including operation of the Pennsylvania Medical Society Liability Insurance Company and the establishment of a fifth administrative council on "health planning and facilities." Other reports submitted for review are those of the Pennsylvania Medical Care Foundation and the Educational and Scientific Trust.

HOUSE OF DELEGATES HEARS CHIROPRACTIC SUIT REPORT

A report from the Board of Trustees on the settlement in the suit brought by the Pennsylvania Chiropractic Society against PMS, the AMA, and others is on the House of Delegates agenda as it meets in Lancaster this week. The report summarizes the terms of the settlement agreed to by the Society's Board of Trustees and presents a chronology of activities leading to settlement. The terms require acceptance of the fact that chiropractors are licensed limited practitioners in Pennsylvania, and that "physicians may or may not, at their discretion, accept patients sent by licensed limited practitioners or any other individual." The Board of Trustees approved the settlement agreement, as did the AMA, after determining that the agreement is not in conflict with the Principles of Medical Ethics. Copies of the report are available on request to the Society.

LEGAL COUNSEL ADVISES MOVING FOR TRIAL COST

The Society's Board of Trustees has issued a recommendation to physicians, based on advice from PMS legal counsel. The recommendation is: "Whenever a PMS member is sued for medical malpractice and honestly believes that suit is brought in bad faith, the member's counsel should be instructed to move for payment of counsel fees."

TWO LINE PRESCRIPTION FORMS NOT ENOUGH FOR HEW RULES

"The use of the two line prescription form (as called for in Pennsylvania law) will <u>not</u> suffice as a means of certification to override MAC (maximum allowable cost) limits on multiple source drugs...certification (for medicaid payment) requires the inclusion of some phrase in the prescriber's own handwriting indicating the need for a specific brand of medication." This was the word received by a PMS task force which visited the

Health Care Financing Administration in Washington seeking clarification. Physicians must write "brand necessary" or a similar statement before medicaid will cover brand name medications.

DR. INGAGLIO CHAIRMAN OF STATE MEDICAL BOARD

Philip E. Ingaglio, MD, of Philadelphia, was elected chairman of the State Board of Medical Education and Licensure October 25. He has been a member of the board since 1972 and most recently served as vice chairman. He succeeds Richard C. Lyons, MD, of Erie, who will remain on the board and was voted the title, "chairman emeritus."

SURVEY TO DETERMINE COST OF PATIENT VISIT

The Society's Medical Assistance Program Improvement Project (MAPIP) has commissioned a survey to determine the actual cost to the physician of a patient's visit to the office. Five hundred physicians will receive this month a request to participate in the scientific survey prepared by an independent practice management consulting firm. The data collected will be used to negotiate an increase of the $6.00 fee now paid to physicians who treat Medical Assistance patients. Society President John V. Blady, MD, in a letter to those physicians chosen to participate, asks that they take the time required to complete the questionnaire, and promises that individual responses will be held in strictest confidence. Survey results will be presented only in the aggregate.

CONSUMER MAJORITY LAW FOR BLUE SHIELD BOARD

The Blue Shield Board of Trustees must be composed of 50 percent consumers according to a law passed by the legislature and signed by Governor Shapp as Act 211 of 1978.

NEW LEGISLATION MANDATES BLOOD BANK RECIPROCITY

Act 200 of 1978 passed by the legislature and signed into law by the governor, calls for enforced reciprocity without regard to geographic location or blood bank affiliation. It says no one shall be denied blood for nonmedical reasons when it is available. The legislation was adopted after a compromise was agreed to by the American Association of Blood Banks and the American Red Cross.

FOUNDATION CONTINUES DRUG UTILIZATION REVIEW

The Pennsylvania Medical Care Foundation has had extended through June 1979 a contract to perform drug utilization review for Capital Blue Cross, fiscal intermediary for the Medical Assistance Program. The Foundation's drug utilization review committees perform the review in each PSRO area.

M D LICENSE RENEWALS NEED CERTIFIED CHECK

The Commissioner of the Bureau of Professional and Occupational Affairs is enforcing a rule requiring that all licensing fees be paid with a certified check or money order. This means that physicians must use one of these means to pay their $75 biennial license renewals which are due now. John F. Rineman, executive vice president, said PMS protested the "bureaucratic harassment" both in person and by letter.

Pennsylvania Medicine

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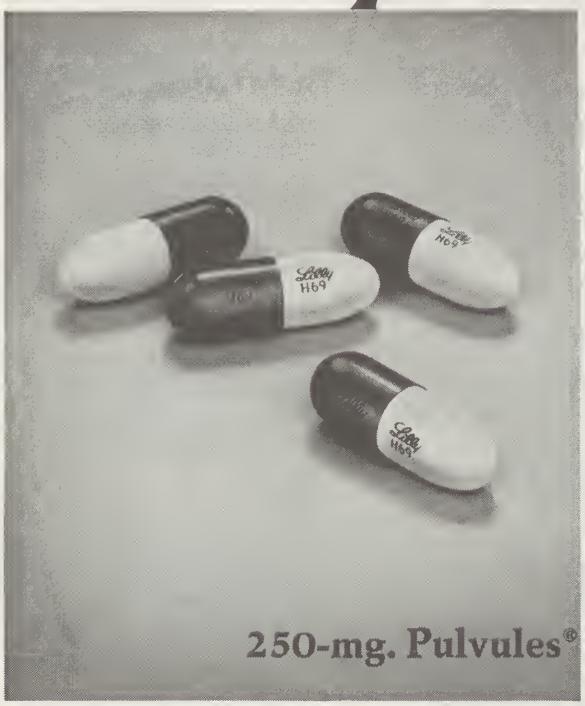
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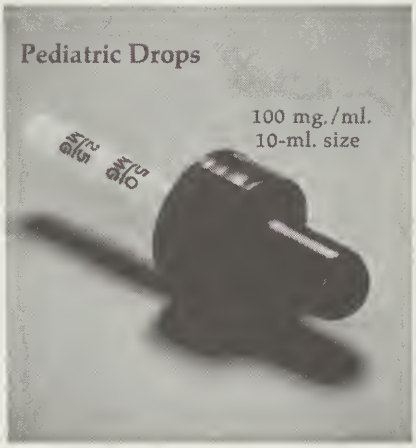
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Cost conference investigates voluntary strategies

A conference on voluntary strategies for health care cost control, cosponsored by the Pennsylvania Medical Society and the Hospital Association of Pennsylvania, was held September 6 and 7 at the University of Pennsylvania in Philadelphia.

Produced by the National Health Care Management Center, the conference brought together 64 representatives of Pennsylvania's industrial, labor, provider, and payor communities to evaluate actions which might be taken voluntarily to control the costs of health care services.

A major goal of the conference was accomplished by bringing together the various components of the health care system and initiating mutual efforts toward the solution of the health care cost problem. "One of the most significant accomplishments of the conference," according to John V. Blady, M.D., Society president, "was the participants' recognition that the cost problem encompasses all segments of the health care industry and that a solution requires the efforts of not *one* group but *all* those involved. In the near future, I hope to see more face-to-face meetings between the individual components of Pennsylvania's health care system."

Faculty members of the University of Pennsylvania began the conference with a series of lectures dealing with the multifaceted cost problem. Participants then met in small working groups to discuss the impact of the health care cost problem on their individual working environments and to describe efforts they have undertaken to deal with the problem. The conference ended with discussion and evaluation of several proposals which documented voluntary strategies for health care cost control.

Physicians representing the Pennsylvania Medical Society at the cost conference were: John V. Blady, M.D., Villanova; David W. Clare, M.D., Pittsburgh; Joseph N. Demko, M.D., Scranton; Henry H. Fetterman, M.D., Allentown; George R. Fisher, M.D., Philadelphia; Raymond C. Grandon, M.D., Harrisburg; Webb S. Hersperger, M.D., Carlisle; and Sidney O. Krasnoff, M.D., Elkins Park.



Officers of the Pennsylvania Medical Society met with other health care professionals and with leaders of industry and labor to investigate voluntary cost control strategies. The University of Pennsylvania was the setting for the conference which was sponsored by PMS and the Hospital Association of Pennsylvania.

Pennsylvania internists form liaison committee

Internal medicine specialists throughout the state soon will speak with a common voice on issues relating to medicine in Pennsylvania. With the creation of a Liaison Committee for Internal Medicine, representatives of the American College of Physicians, the Pennsylvania Society of Internal Medicine, the Association of Professors of Medicine, and the Program Directors in Internal Medicine hope to develop joint policy statements that may speak to the needs and concerns of patients requiring internal medicine services.

Representing each branch of the new committee are: **American College of Physicians**—John Hill, MD, Pittsburgh, governor for the western Pennsylvania region; and George Jackson, MD, Harrisburg, governor for the eastern Pennsylvania region. **Pennsylvania Society of Internal Medicine**—George Fisher, MD, Philadelphia, president; and James Regan, MD, Bethlehem, president elect. **Association of Professors of Medicine**—Sol Sherry, MD, and Donald Kaye, MD, both of Philadelphia. **Program Directors of Internal Medicine**—John Moyer, MD, Johnstown.

Robert Pressman, MD, Philadelphia, representative for internal medicine on the State Society's Interspecialty Committee, also has joined in efforts to form the committee.

State Society acts on prison health plan

The Pennsylvania Medical Society has initiated a new prison health accreditation program to improve medical care in Pennsylvania's county jails.

James J. Houser, MD, Franklin (Venango County), chairman of the Society's Jail Health Advisory Committee, said, "Jails are a documented breeding ground for infectious and contagious diseases which endanger the public as well as the inmates and prison employes. Many jails do not have adequate medical care programs. Our objective is to assist all county jails in Pennsylvania to achieve adequate standards of medical care and health services."

The voluntary Jail Health Accreditation Program is sponsored by the American Medical Association (AMA), and the Law Enforcement Assistance Administration of the US Department of Justice. It requires a four step review, including on site inspection by a health care team, as well as maintenance of *Standards for the Accreditation of Medical Care and Health Services in Jails,* established by the AMA.

Other members of the Jail Advisory Committee are John Belfonti, assistant to chief, health care section, Pennsylvania Bureau of Correction; Gladys Keiper, RN, director, Division of Institutional Nursing, Pennsylvania Department of Health; Walter G. Scheipe, warden, Berks County Prison; Douglass Thompson, MD, Magee's Women's Hospital, Pittsburgh; James A. Collins, Jr., MD, Geisinger Medical Center, Danville; and Theodore L. Yarboro, MD, Sharon.



The goal of the prison health accreditation program is to provide standards for adequate health care at such institutions as Delaware County Prison.

State funds research in pneumoconiosis early detection

Four research proposals for investigating the feasibility of early detection of coalworkers' pneumoconiosis recently were funded by the Pennsylvania Department of Health following review in August by a peer review board.

Named to receive a portion of the $100,000 appropriated for the program are: David Murphy, MD, of the University of Pennsylvania School of Medicine; Joseph Watson, PhD, of the Graduate School of Public Health at the University of Pittsburgh; Allan Freedman, MD, of Hahnemann Medical College and Hospital; and C. C. Li, PhD, of the University of Pittsburgh's department of electrical engineering.

Particular areas of concern include: identification of susceptible individuals; screening; early identification of the disease; and investigation of immunological deficiencies contributing to the disease.

The peer review board for 1978-79 awarded the grants under authority delegated by the governor and his advisory committee, chaired by Warfield Garson, MD. Members of the board are: Alfred Fishman, MD, chairman; Katherine Sturgis, MD; Philip Enterline, PhD; William Weiss, MD; Eugene Grebner, PhD; Robert Johnston, MD; John Kibelstis, MD; Richard Naeye, MD; and William Atkinson, MD. The program, administered by the Department of Health, originated in the Division of Chronic Respiratory and Occupational Disease Services under the direction of Evan D. Riehl, MD.

PMS wins first round in battle for medical care equality

The Department of Public Welfare (DPW) has been stopped temporarily from implementing a department regulation banning most benzodiazepines for Medical Assistance patients. Judge Daniel H. Huyett, III, of the U.S. District Court for the Eastern District of Pennsylvania, issued the temporary restraining order.

The Pennsylvania Medical Society won this first round in its suit against DPW October 12. Judge Huyett set November 16 as the date for a hearing on a permanent injunction in response to the suit filed by PMS October 6.

Joining the Society as plaintiffs are: MA patient David S. Bowers, an epileptic, who requires a benzodiazepine (Clonopin®) for control of seizures; Mrs. Dolores Wright, a welfare recipient from Pittsburgh who requires Valium® for control of muscle spasms (class action); the Pennsylvania Welfare Rights Organization; Joseph M. Sienkiewicz, MD, Mount Carmel; Robert Poole, III, MD, West Chester; Robert R. Rundle, a pharmacist from Reading; the Pennsylvania Pharmaceutical Association; and the Pennsylvania Osteopathic Medical Association.

Defendants include Secretary of Welfare Aldo Colautti; Roger A. Cutt, commissioner of the Office of Medical Programs for DPW; Don Jose Stovall, executive director, Philadelphia County Board of Assistance; and O. K. Stephenson, MD medical director for the DPW Office of Medical Programs.

Judge Huyett's order said: "physicians may continue to prescribe Valium and other benzodiazepines for welfare patients. Benzodiazepines have been reinstated as compensable items."

A regulation published in *Pennsylvania Bulletin* on September 23, to become effective October 1, precipitated the Society's suit. In it DPW said: "Numerous comments were received, all of which objected to the limitations on payment for benzodiazepines. Since medical evidence indicates that chlordiazepoxide is clinically equivalent to and may be safely substituted for the more expensive brand name drugs, the proposed regulations are being adopted without modification."

The Society responded with a report which concluded: "Chlordiazepoxide is not clinically equivalent to and may not be safely substituted in all cases for the benzodiazepines . . . and there is no basis in the administrative record for the finding by DPW."

At a press conference October 5, George A. Rowland, MD, chairman of the Society's Board of Trustees, accused DPW of practicing medicine without a license and discriminating against the poor. He announted the Society's intention to file suit and said that the exempt drugs, including chlordiazepoxide, cannot, consistent with sound medical practice, be substituted in all cases for the benzodiazepines.



Theodore L. Yarboro, MD (above), a family physician from Sharon, represented the State Society in September 6 testimony before the Special Senate Committee on Medical and Veterinary Training at State Institutions. Dr. Yarboro, a member of the PMS Commission on Education and Manpower, discussed the Society's policies on physician distribution, desirability of a new medical school in the Commonwealth, and availability of minority physicians in the state.

Board sets policy on smoking, prescribing amphetamines

Two position statements, one on smoking and the other on amphetamines used as an anorexiant, were adopted by the Board of Trustees at its August 23 meeting.

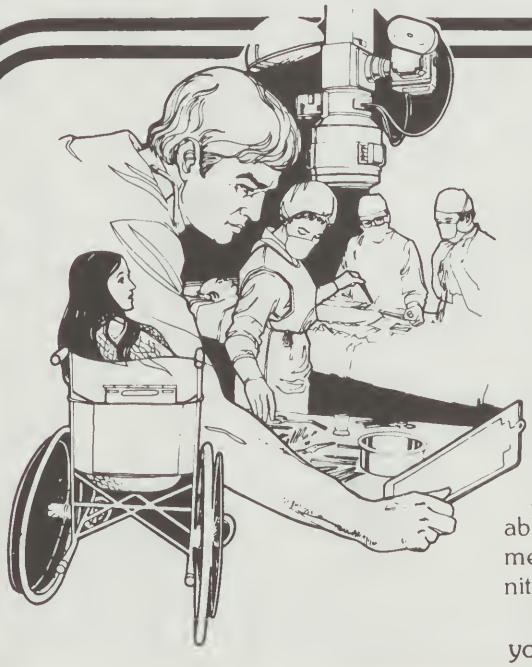
Health hazards associated with smoking prompted the Board to make the following recommendations:

- That the role of smoking as a public health hazard be recognized.
- That the Society actively encourage and undertake appropriate patient education efforts designed to minimize health risks attributed to smoking.
- That since physicians should be leaders in establishing personal health patterns which result in healthy living, we should by example and supportive encouragement assist our patients to stop smoking.

Having considered the benefits and deleterious effects of amphetamines as an anorexiant agent in the treatment of obesity, the Board adopted the position: "that amphetamines as an anorexiant be identified as a specific example of 'inappropriate use of drugs.' "

The statement, referring to current medical literature on the usefulness of amphetamines, cites an article by Lester Grinspoon, MD, and James D. Bakalar ("The amphetamines: medical uses and health hazards," *Psychiatric Annals* 7:8, August 1977, 381-390) which concludes: "People who have problems controlling their need for constant gratification as indicated by compulsive eating find it hard to put aside a medication that makes them feel good. Many patients consider their attempt to lose weight doomed to failure once they lose this magic potion that protects them from themselves. When the drug is discontinued, a psychologic vacuum is created that must be filled with food. Some patients gain back even more weight than they have lost. So although short-term use of the drug causes a short-term weight loss, it also helps the patient avoid the issue of changing his eating habits. For these reasons we doubt the wisdom of using amphetamines for weight reduction under any circumstances."

A rebate totalling $14,814.96 was received this year by the State Society based on AMA membership reported for 1978, a decrease of $3,166.94 from the 1977 sum. Fifty percent of the refund from AMA dues will be shared by the 58 counties reporting AMA membership prior to March 15. A rebate of $2.99 per member will be given to those counties that reported in January; reduced amounts of $.64 and $.33 per member will be refunded to those that reported in February or between March 1 and March 15.



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AIR FORCE. HEALTH CARE AT ITS BEST.

Philadelphia CMS stars in new video health seminar



"Doctor's Appointment," the television series cosponsored by the Philadelphia County Medical Society and WCAU-TV (Channel 10), brings practical information on health care to viewers in the metropolitan area. In discussion on the segment, "What do hormones do?" are, left to right, Doris Bartuska, MD, Angelo M. DiGeorge, MD, and John Helwig, Jr., MD, president of the county society, who serves as moderator for the series.

Prevention, care, and cure of common medical problems are the subjects of "Doctors' Appointments," a series of seminars being presented on TV 10 (WCAU, Philadelphia). Featuring 39 programs, the series began on Monday, September 18 and will continue until Friday, December 15. The program is aired from 6:30 to 7 a.m. Monday, Wednesday, and Friday mornings.

"Doctors' Appointments" is produced in cooperation with the Philadelphia County Medical Society. John Helwig, Jr., MD, president of the society, hosts the show. Dr. Helwig is cardiovascular specialist at Germantown Hospital and professor of medicine at Temple University.

"Doctors' Appointments" is surveying a variety of health concerns, ranging from headaches to heart attacks and including medicare and medicaid. Dr. Helwig said, "The range of our topics concernsthe human condition from conception to old age . . . from the selection of a doctor to the anatomy of a hospital . . . from conditions which affect your emotional health to others which affect your physical well-being."

On each program guest specialists present their particular subjects. Past participants who have appeared as guests on the program include:

Mr. Joseph F. Farrell; Mr. Mark S. Levitan; Michael T. McDonough, MD; Peter A. Theodos, MD; Carole W. Soskis, Esquire; Jerome Miller, DO; Frances S. Esposito, MD; R. Robert Tyson, MD; Sidney O. Krasnoff, MD; Peter T. Kuo, MD; Luigi Mastroianni, Jr., MD; Helen O. Dickens, MD; Hope Punnett, PhD; William J. Mellman, MD; Iain Black, MD; L. Henry Edmunds, Jr., MD; Albert J. Finestone, MD; Paul J. Poinsard, MD; Perry S. MacNeal, MD; Stephen D. Silberstein, MD; Lester Baker, MD; Charles R. Shuman, MD; Susan H. Bray, MD; Lawrence Earley, MD; Charles E. Hartford, MD; Frederick A. DeClement, MD; Winston M. Bryant, Jr., MD; Myron Yanoff, MD; Norman N. Cohen, MD; Charles C. Wolferth, MD; Peter Randall, MD; Myron E. Rosenfeld, MD; Dorothea D. Glass, MD; Henry S. Wieder, Jr., MD; Walter P. Lomax, MD; Albert N. Brest, MD; Sol Sherry, MD; Harold A. Wurzel, MD; Donald F. Heiman, MD; John Y. Templeton, III, MD; Edward J. Resnick, MD; Mary E. Moore, MD; Sylvan Eisman, MD; George P. Rosemond, MD; Angelo M. DiGeorge, MD; Doris Bartuska, MD; Wallace G. McCune, MD; Morton S. Ward, MD.

The remaining schedule of programming for the series is:

11/13/78 "Medicaid and medicare problems"-Mr. Thomas L. Hooker, Robert B. Edmiston, MD

11/15/78 "Care of the sick and dying"-Jay W. MacMoran, MD, Edward D. Viner, MD

11/17/78 "VD"-Mr. Robert Levinson, Donald Kaye, MD

11/20/78 "Preventive medicine"-Willard A. Krehl, MD, PhD, Ira Gabrielson, MD

11/22/78 "Iatrogenic diseases"-Robert Moser, MD, Donald R. Cooper, MD

11/24/78 "Epilepsy"-William F. Bouzarth, MD, Alan S. Troupin, MD

11/27/78 "Stroke and rehabilitation"-Brooke Roberts, MD, Emmeline Gutierrez, MD

11/29/78 "Anemia, leukemia and tired blood"-Isadore Brodsky, MD, William E. Barry, MD

12/1/78 "Down in the dumps"-H. Keith Fischer, MD, Arthur Huntley, MD.

12/4/78 "Alcoholism and drug abuse"-Samuel B. Hadden, MD, Manuel M. Pearson, MD

12/6/78 "Emergency"-David T. Reed, MD, David K. Wagner, MD

12/8/78 "The high cost of health care"-William Y. Rial, MD, Edward Stemmler, MD

12/11/78 "Asthma and emphysema"-Philip Kimbel, MD, Charles Egoville, MD

12/13/78 "Flu and viral disease"-Robert Weibel, MD, Harvey M. Friedman, MD

12/15/78 "Ear, nose and throat problems"-Jennifer A. Allcock, MD, Wayne Weddington, MD

MDs in the news

D. Ernest Witt, MD, of Bloomsburg, served as chairman of the committee on scientific program for the 1978 Scientific Assembly of the American Academy of Family Physicians. The meeting, held in San Francisco in September, was attended by more than 3000 physicians.

Thomas H. Kreulen, MD, of Wayne, has been appointed chief of cardiology at the Graduate Hospital, Philadelphia. Since 1972 Dr. Kreulen has been assistant professor of medicine and director of the cardiac catheterization laboratory at the Temple University Health Sciences Center.



Dr. Kreulen



Dr. Clifford

Maurice C. Clifford, MD, Mt. Airy, has been elected vice president for medical affairs at the Medical College of Pennsylvania. Dr. Clifford is clinical associate professor of obstetrics and gynecology at MCP.

John H. Moyer, MD, recently was appointed director of regional/educational affairs at Temple University School of Medicine. Dr. Moyer, a professor of medicine at the university, will coordinate health/education activities in the Cambria-Somerset area.

A brief report on Legionnaire's Disease by **Gary L. Lattimer, MD,** and **L. V. Rhodes, III, MD,** of Allentown, appeared in the September 8, 1978 issue of JAMA.

Robert E. Wharen, MD, of Williamsport, has been named Pennsylvania Physician of the Year by the Governor's Committee on Employment of the Handicapped. A physiatrist, Dr. Wharen is director of the muscular dystrophy clinic at Williamsport Hospital's Rehabilitation Center.

The formal investiture of **William Likoff, MD,** as president of Hahnemann Medical College and Hospital took place on September 26. Among those having major roles in the ceremonies were R. Buckminster Fuller, inventor of the geodesic dome; Eugene Ormandy, conductor of the Philadelphia Symphony Orchestra; actor Walter Matthau; **Jonathan E. Rhoads, MD,** professor of surgery at the University of Pennsylvania School of Medicine; **Katharine B. Sturgis, MD,** emeritus professor at the Medical College of Pennsylvania; and the presidents of the five Philadelphia medical schools: Marvin Wachman, PhD, Temple University; **Lewis W. Bluemle, Jr., MD,** Thomas Jefferson University; **Robert E. Cooke, MD,** Medical College of Pennsylvania; and Thomas R. Rowland, Jr., LLD, Philadelphia College of Osteopathic Medicine.

Allen R. Myers, MD, of Ardmore, has been named professor of medicine and director of the teaching program of the department of medicine at Temple University Medical Center. Dr. Myers is former president of the Philadelphia Rheumatism Society.

Sherwood C. Young, executive director of the Berks County Medical Society, recently completed a postgraduate course in medical association management at Northwestern University in Evanston, Illinois. Young was among 30 executives to take the course at the university's graduate school of management. Young, an affiliate member of the State Society, has been executive director of the county society since 1961.

Four physicians recently were appointed to the neurology staff at the Medical College of Pennsylvania.

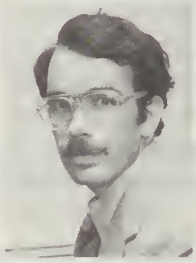
Jack O. Greenberg, MD, Philadelphia, chairman of neurology at Episcopal Hospital, is now a full professor at MCP. **Richard T. D'Addario, MD,** Ambler, has been named an assistant professor. He is also deputy director of neurology at Episcopal. **Daniel L. Skubick, MD,** Strafford, an expert in directional Doppler examination of the carotid arteries, has been named



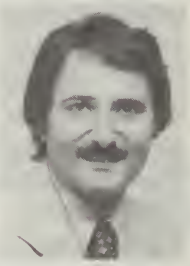
Dr. Greenberg



Dr. D'Addario



Dr. Skubick



Dr. Cohen

instructor in neurology. Also an instructor is **Michael Martin Cohen, MD,** Philadelphia, who will design a neuro-ophthalmology laboratory at MCP.

John L. Neigh, MD, has been named director of anesthesiology at Presbyterian-University of Pennsylvania Medical Center. Dr. Neigh served as an anesthesiologist at the university's hospital and as chief of anesthesiology at Veterans Administration Hospital in Philadelphia before accepting his current post.

A well-known "hometown" physician, **Fred H. McClain, Jr., MD,** was recognized as the Citizen of the Year by the Mount Union chapter of the Knights of Columbus. Dr. McClain has served his hometown for 31 years.



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Parenteral administration is not recommended in the presence of hypotension or tachycardia.

Intravenous administration should not be given because of increased likelihood of side effects.

Adverse Reactions: On rare occasions oral administration of the drug has been associated in time with the occurrence of hypotension, tachycardia, nausea, vomiting, dizziness, abdominal distress, and severe rash. If rash appears the drug should be discontinued.

Although available evidence suggests a temporal association of these reactions with isoxsuprine, a causal relationship can be neither confirmed nor refuted.

Administration of single dose of 10 mg. intramuscularly may result in hypotension and tachycardia. These symptoms are more pronounced in higher doses. For these reasons single intramuscular doses exceeding 10 mg. are not recommended. Repeated administration of 5 to 10 mg. intramuscularly at suitable intervals may be employed.

Supplied: Tablets, 10 mg., bottles of 100, 1000, 5000 and Unit Dose; Tablets, 20 mg., bottles of 100, 500, 1000, 5000 and Unit Dose; Injection, 10 mg. per 2 ml. ampul, box of six 2 ml. ampuls.

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Precautions: Use with caution in patients with cardiac disease, hepatic or renal impairment. Concurrent administration with certain antibiotics, i.e. clindamycin, erythromycin, troleandomycin, may result in higher serum levels of theophylline. Plasma prothrombin and factor V may increase, but any clinical effect is likely to be small. Metabolites of guaifenesin may contribute to increased urinary 5-hydroxyindoleacetic acid readings, when determined with nitrosonaphtol reagent. Safe use in pregnancy has not been established. Use in case of pregnancy only when clearly needed.

Adverse Reactions: Theophylline may exert some stimulating effect on the central nervous system. Its administration may cause local irritation of the gastric mucosa, with possible gastric discomfort, nausea, and vomiting. The frequency of adverse reactions is related to the serum theophylline level and is not usually a problem at serum theophylline levels below 20 μg/ml.

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Confidentiality is keystone

Functioning of Committee on Impaired Physician outlined

Edward J. Resnick, MD

In 1976 the *New York Times* published a series of articles about incompetent physicians that created a great stir. Among other things, the *Times* claimed that as many as 16,000 licensed physicians, or 5 percent of the medical profession, are unfit to practice medicine, but only about 72 physicians in the entire United States lose their licenses each year because of incompetence. However, the *Times* failed to mention anywhere in its series of five articles what American physicians are doing to help their colleagues with impaired health.

Almost a year before the *Times* articles, a major conference was held in San Francisco. Sponsored by the American Medical Association, its theme was "The Disabled Doctor—Challenge to the Profession." The purpose was to stimulate and encourage action to meet that challenge.

During the conference, it was pointed out that the *Times* was probably correct in its estimate of physician impairment. For example, it was shown that an alcoholic physician is more likely to lose his driver's license than his medical license. Only 1-2 percent of physicians come to official attention because of marked drug dependence. Between 7 and 8 percent of physicians may become alcoholics; and even if half of these are affected in their ability to practice medicine, there are still 10,000 impaired alcoholic physicians in the United States. A full 100-student medical school graduating class is required each year just to replace the number of physicians who commit suicide. And yet, up until a few years ago, only a few state societies had any mechanism to handle the problem of the impaired physician.

The San Francisco conference reviewed the dimensions of the problem, known methods of attacking it, and the measures already being taken in some states. Recommendations included encouragement of state medical society programs, enactment of improved medical practice legislation, and suggestion of improved treatment methods for impaired physicians.

Even before the *Times* series, the Pennsylvania Medical Society had been working on the problem. By the autumn of 1976, an ad hoc committee of our Society was working on a program for Pennsylvania. The committee presented its program to the Board of Trustees in March 1977 and in June 1977 the Board authorized an impaired physician program.

Under the supervision of the permanent Committee on the Impaired Physician, this program is now in full operation.

The Committee believes that the problem of the impaired physician is the responsibility of the medical profession. The purpose of the program is to establish a noncoercive program for finding and helping physicians who have become impaired because of alcoholism, drug dependency, mental, physical, or aging problems.

The program encourages the earliest possible intervention, when the impaired physician's resources may still be intact and before serious harm has been done to professional reputation or to the public. The Committee has designed the program so that all actions taken on behalf of the impaired physician will preserve unimpaired his right to continue practice without restriction on recovery. All actions are intended in the best interest of the physician and the public. Referral to any other agency, such as the State Board of Medical Education and Licensure, will be considered only when the impaired physician's actions endanger the public or himself and he refuses assistance. In keeping with the non-punitive aspects of the program, such referral would not be made by the Committee itself.

The impaired physician program is run from a central office administered by the Pennsylvania Medical Society. The program is managed by the Impaired Physician Committee with the assistance of Society staff. The Committee has established and is maintaining a resource registry of interveners, who are selected for their expertise in the areas of alcoholism, drug abuse, mental health, and geriatrics. They may be rehabilitated impaired physicians. A team of interveners is selected by the Impaired Physician Committee in each case.

It is the responsibility of the intervention team to contact the impaired physician, encourage him voluntarily into active treatment, assist him to continue his professional duties or to return to them as soon as possible, and maintain contact with the impaired physician to support and encourage his cooperation and treatment. No member of an intervention team is involved in the treatment process.

A confidential telephone number at PMS headquarters has been established: (717) 763-7937. Contacts have been made to this number, and the program has started operations. Prompt follow-up is made by members of the Impaired Physician Committee on call to this confidential number.

When the impaired physician himself contacts the program, the committee assigns an intervention team, which becomes an advocate for the physician as he undergoes treatment. The Committee also accepts from any responsible source (other physicians, physician's spouse, etc.) information indicating that a physician may be impaired. In such cases, the Committee evaluates the information given, making as much use as possible of firsthand information concerning specific incidents of demonstrated impairment. All information gathered by the Committee is completely privileged and confidential under Pennsylvania law. If the Committee finds sufficient cause to justify contacting the physician thought to be impaired, members select an intervention team, which contacts the impaired physician and helps him on the road to recovery.

Dr. Resnick, a member of the State Society's Impaired Physician Committee, is an orthopedic surgeon at Temple University Hospital and secretary of the Philadelphia County Medical Society.

Office counseling series

Does sexual stereotyping affect medical care?

Marion Zucker Goldstein, MD
Joyce D. Kales, MD
Carmela F. deRivas, MD

The primary care physician needs to be familiar with societal issues affecting women patients. Our culture's rapidly changing view of feminine roles affects the physician's perspective with regard to physical and emotional health norms in women, and will ultimately affect patterns of medical care. The authors feel that it is timely and helpful to discuss womens' perspectives of their medical care. This article, the tenth in a series, explores physicians' attitudes towards the woman patient and her particular emotional needs.

Common stereotypes of women

Women still live with stereotypes of feminine behavior that consist of several facets. Generally, a woman is expected to be ever-available, and to nurture and care for her family. She is expected to give priority to housekeeping and the raising of children over the development of a career or any other personal interests she might have. Sexually, she is expected to be more passive and compliant, but she must also be pleasing and responsive to her partner's demands. Usually she is discouraged from expressing anger directly, and instead is taught to be devious and indirect in communicating such feelings. Self-assertion on the part of women is often considered abrasive and out of place; the assertive woman is frequently labeled as "unfeminine," and the unfortunate result can be the inducement or aggravation of conflicts concerning her personal identity.

Despite the psychological limitations that stereotyping imposes, women are in fact assuming greater economic responsibility. Nearly half of all mothers with children under age 18 were in the labor force in 1976, compared with nine percent in 1940. More than half of those women who are heads of households and who are mothers of children under age six are in the labor force. Over seven million families are headed by women.[1] Overall, economists project that one half of American women over age 16 will be in the work force within two to three years.

Due to the current emphasis on population control and the decreasing number of years occupied with child bearing and rearing, women are advancing toward a new identity and meaning, increased social contact and recognition, and financial rewards, all of which are engendered by the work performance that has long defined a man's social role and identity.[2]

Male perspective in medicine

Although admissions of women to medical schools have increased to about 23 percent during the past several years, and are still rising, medical education remains a male-dominated field. Men still are the primary health care providers for women, but women patients constitute considerably more than 50 percent of most physicians' practices and of hospital admissions.

When women meet together with each other either socially or in consciousness-raising groups, one of their recurring observations is that physicians are patronizing toward women. To bring this to their physician's attention means challenging traditions and customs that have become ingrained in medical practice and in our culture in general.

Many women feel that their physicians do not attempt to understand their needs, and to communicate their concerns adequately requires a great deal of self-assertion and confidence on their part. Physicians have generally assumed they know what is best for the woman by virtue of their training, which in our advanced technology receives a far greater emphasis on scientific fact than on sensitivity, awareness, and knowledge of psychological and sociocultural issues. This technological orientation may put the contemporary physician at a marked disadvantage in treating his patients, particularly women, many of whom have become skeptical of the assumed authority of the physician. They are eager to become more informed about their own anatomy and physiology, and they are becoming more insistent upon having greater involvement in their treatment options. A recent book by Gena Corea entitled, "The Hidden Malpractice," surveys womens' concerns in this area in detail.[3]

The medical profession has provided a great deal of peer support and role modeling for traditionally accepted attitudes and approaches toward women that may cause resentment on the part of women patients. Collective support among women reinforces their demands not only to be treated with the same respect and privileges accorded to men, but also to receive medical care that is sensitive to their needs as women. As more women become concerned with these issues, certain medical approaches will require modification.[4]

This is the tenth in a series of office counseling articles, a project of the departments of psychiatry of Pennsylvania's medical schools and the Pennsylvania Psychiatric Society. This article and those preceding it were prepared under the direction of the department at the Pennsylvania State University, Milton S. Hershey Medical Center. Dr. Goldstein is medical director of day care services at St. Francis General Hospital, Pittsburgh. Dr. Kales is director of the division of community and social psychiatry at Hershey. Dr. deRivas is medical director of the Central Montgomery County Mental Health/Mental Retardation Center, Norristown. She also is president of the Pennsylvania Psychiatric Society (PPS). Dr. Goldstein is chairperson of the PPS Committee on Women, and Dr. Kales is a committee member.

The care-giving process

The waiting room—More women are finding it essential to respect their own time commitments, and consequently expect the same respect and consideration of their time from their physicians. The traditionally long wait in many doctors' offices is in dire need of modification to adjust to changing lifestyles. In most other professional situations, it is considered common courtesy and evidence of mutual respect to be available at the appointed time. The question arises whether men patients are treated more as the physician's equals and their time respected.

The examining room—It is often customary in doctors' offices to request that the patient disrobe and lie down on an examining table, at times with her feet up in stirrups in the lithotomy position, before she has been given an opportunity to speak with the physician. This can be quite disturbing to a woman who has come to the physician as a patient who is vulnerable, somewhat helpless and perhaps in pain. Also, the assumption of inappropriate familiarity and a condescending attitude take the form of calling the patient "honey" or "dear," or casually using her first name. This is another approach to which women patients frequently object.[5]

The need for reassurance—Women frequently visit their doctor to be reassured that they are physiologically normal. They often need to alleviate anxiety over possible pathology in their reproductive organs during the onset and course of menstruation, course of pregnancy, labor, and delivery, or during the onset and course of menopause. Since many women have only a minimum knowledge of their own anatomy and physiology, they are vulnerable to vivid fantasies and subject to subtle innuendos or overt admonitions that they are "imagining things." A sensitive and patient explanation of anatomy, physiology, and when appropriate, pathology, is needed to help the woman distinguish between fact and fantasy, to relieve her anxiety and depression, or to alleviate the somatization that may be the manifest expression of these emotions. Only when this has taken place can the physician and the patient define the functional and organic components of her chief complaint.

Concerns unique to women—Dysmenorrhea, nausea during pregnancy, pain in labor, and menopausal symptoms are often regarded as either entirely or mostly psychogenic in nature, occurring as they do only in women. However, these symptoms have distinct physiologic etiologies: dysmenorrhea is related to ovulatory cycles; nausea during pregnancy is related to high levels of estrogen, and is mimicked by the effects of oral contraceptives; pain in labor is due to strong visceral contractions against the obstructing fetal parts, and menopausal symptoms occur when the ovaries cease to function. When these symptoms are presented, reassurance alone may be insufficient treatment, and symptomatic relief should be considered.[6] Physicians who believe these disorders are entirely due to psychogenic factors may be depriving women of appropriate reassurance, education, or treatment.

Treatment recommendations—It is not uncommon for physicians to give orders without explanation or education, or to dismiss the overt complaint by indicating that it is "just in her mind." This is generally perceived as offensive and condescending by women, even when no harm is meant.

Current and unbiased information is essential for a woman to decide intelligently on methods of prevention or termination of pregnancy. The physician should provide her with the information necessary to make an educated, contemplated decision, thus helping her live with her decisions more comfortably, whatever they may be. The physician's moralizing or bringing his own value system to bear on the patient's decision is unwise and may only compound any conflict that already exists. When the male partner's involvement and participation in these decisions is appropriate, it should not be confused with giving him authority to make the decision on her behalf, and allowing him to violate the doctor-patient relationship.

Women have been concerned that hysterectomies are too readily recommended after their reproductive organs have ceased to function, and that there is little concern for the emotional significance of losing these parts of the body. The same is true for radical breast removal, where the extent of the physical mutilation and grief is minimized rather than dealt with openly.

If the woman seeks another opinion before accepting the physician's recommendation, or simply wants more consideration for her own concerns, she is not necessarily questioning the physician's competence but is merely protecting herself as a thinking adult. The physician should respect her for her desire to be informed and should not become defensive, reject her, or withhold care.

Norms for emotional health

Two-thirds of psychiatric outpatients are women, and 60 percent of admissions to private mental hospitals are women. Women use more psychotropic drugs than men do, and although men have more completed suicides, women attempt suicide twice as often. The diagnosis, "involutional melancholia," is made for women with two to three times greater frequency than for men. These statistics raise questions as to whether the accepted "norms" for emotional health in

women are biased. We might also question whether an attitude exists in our organizational systems—vocational, family, academic, recreational, or health care delivery—that is stressful to women.

Indeed, men also experience stress when they are subject to stereotyping and those expectations of our culture to which they may not wish to conform: the 80 hour work week, the expectation not to show emotion, the pressure to compete, and the assumption that career advancement will be placed before family considerations. Instead of having open choices for a balanced commitment to personal growth and care of others within the family, many men find themselves trapped in this stereotype of "norm," which takes its toll in increased cardiovascular disorders in men and manifestations of distress in children who have been deprived of adequate "fathering."

Our culture needs a more equitable distribution of affection and caring for others, domestic responsibility, and making contributions away from home. If ample reward and recognition for all of these activities were shared by men and women, much of the stress that plagues both sexes would be alleviated.[7]

The older woman patient

The middle-aged and elderly woman has received even less concern and respect in our society than the attractive, younger woman. Most older women are widowed and have lost their central roles of wife and mother. Over one-third of women over 65 live alone, and by the year 2000 it is estimated that there will be 150 women over 65 to every 100 men. The medical profession needs to give more concern to care of the aging in general and older women in particular.

The older woman is still expected to do for herself as her sources of support are diminishing. She must cope with progressive loss of physical strength, frequent diminution of vision due to cataracts or glaucoma, hearing and memory loss due to arteriosclerosis, diminished mobility, and recurring mourning because of loss of friends and family. It is often impossible for her to have a physician make a house call, and the community often fails to provide her with safe transportation. Since excessive medication is frequently substituted for more comprehensive care and understanding, the older woman is often overmedicated, leading to additional symptoms. Closer attention to psychosocial factors would in many cases alleviate the need for pharmacologic treatment.

The physician's role

The physician needs to be aware of his own emotions and attitudes in order to understand whether his reaction to a particular female patient is a defense against experiencing his feelings more overtly on a conscious level. If the patient seems seductive, the physician should neither be seduced nor label her "hysterical." On the other hand, some women tend to relate to their doctors in a childlike manner. Although this kind of behavior is frequently accepted as a cultural norm of feminine behavior, the physician should avoid responding in a paternal manner that is patronizing or condescending. Rather, the woman's mature coping skills should be elicited by interacting with her in an adult-to-adult fashion.

Physicians have often categorized women's complaints with labels such as "housewife's anxiety syndrome," "empty-nest syndrome," attention seeking by the "neglected wife," and so on. These categorizations are often formulated because the stages of woman's life cycle are intimately linked to the reproductive cycle and child rearing, and many women feel a lack of satisfaction and autonomy when societal and familial expectations at a given stage of life seem to limit their opportunities for personal satisfaction. Unlike their male counterparts, women usually perceive themselves as having a minimum of mobility and opportunity to change their everyday lives for the better; they feel tied to their homes and children, and in comparison with men, see themselves as having fewer acceptable opportunities for expressing themselves. Women see themselves as having the option of "take it or leave it," rather than the confidence that change is possible even in the most ungratifying of situations. Many do leave, as evidenced by the rising divorce rate; but when staying and "taking it" is an unsatisfactory compromise, the incidence of the various "female syndromes" rises. The unspoken complaint is that of feeling "trapped" and the protest is expressed either in somatic symptoms without physical bases, or in frank psychiatric complaints of anxiety, depression, suicidal thoughts, insomnia, and phobias with obscure etiologies. In some instances, if the woman protests directly, severe marital discord and even domestic violence may occur.

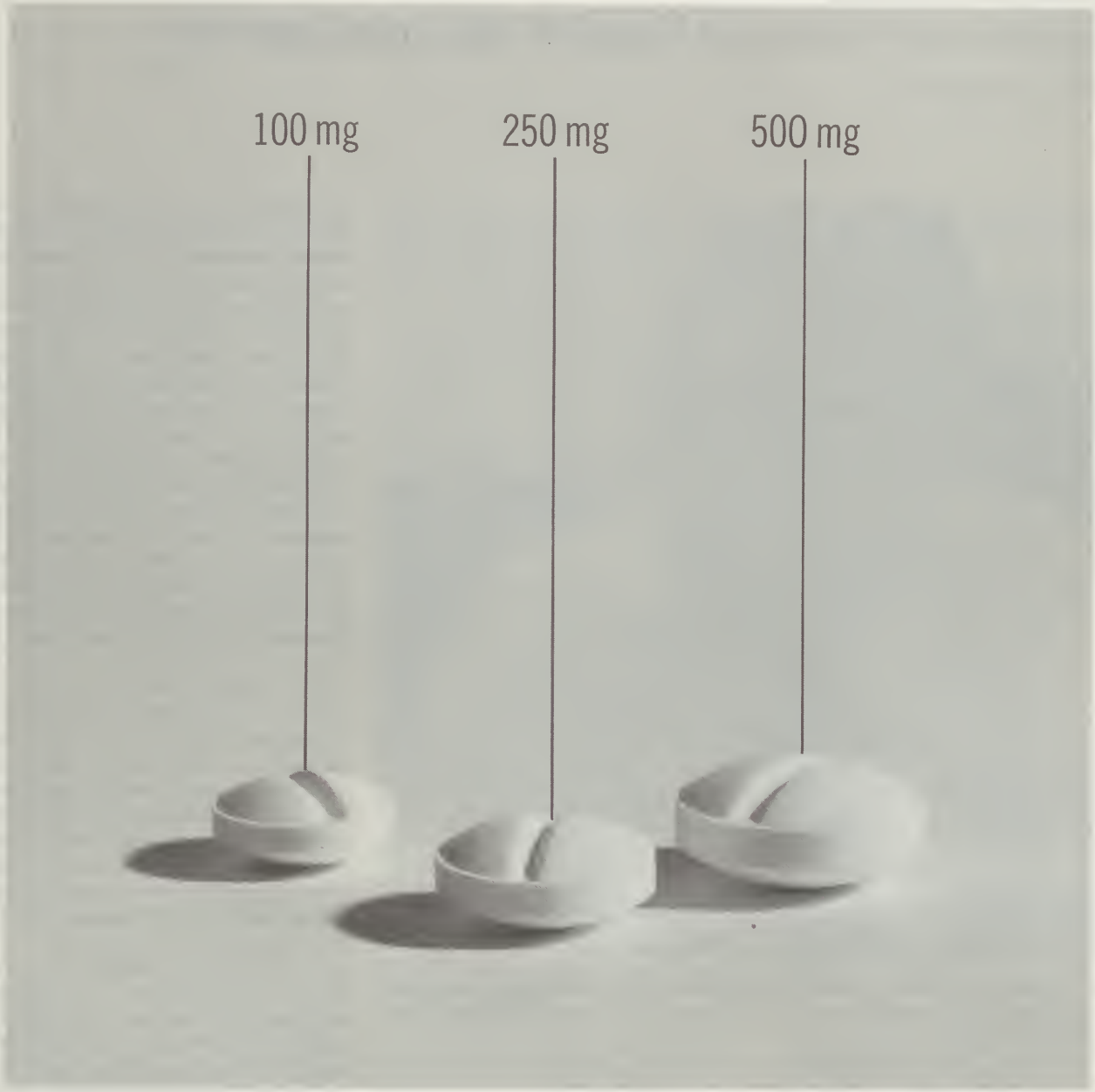
The physician may become uneasy when his patients express concerns that are similar to those expressed by his wife because of intermittent dissatisfaction with her own role assignment in the family. It may be helpful for the physician to show an interest in helping the woman recognize her conflict over her life situation and help her to arrive at alternate ways of dealing with it. More adequate preparation for the various stages of a woman's life would make each one less traumatic, and adaptation more comfortable.

Summary

Medical advances, the population explosion, and societal change have mandated changing the stereotyped view of woman's role at various stages of the life cycle. To become more sensitive and responsive to women's needs for emotional growth and development and changing self-image during various life stages, physicians can carefully examine their expectations, stereotypes and office practices, in order to provide women with a more effective doctor-patient relationship.

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No rugged individualism allowed

Medical staff is key in hospital risk management

Robert L. Lambert, MD



'The "rugged individualism" so dear to the physician in the office has no place in the hospital where the medical staff, as a group, is held accountable for the actions of its individual members.'

An extended hospitalization early in his career made a lasting impact on the author's future. He has been involved in improving the quality of care for hospitalized patients throughout his professional life, as hospital medical director, member of the teaching faculty of the Joint Commission on Accreditation of Hospitals, member of the Statewide Professional Standards Review Council, and activist in quality assurance and peer review activities of organized medicine.

He has been medical director of the Pennsylvania Hospital Insurance Company for nearly two years. Before that time he served for 18 years as medical director of the Hospital of the Medical College of Pennsylvania in Philadelphia. After earning his baccalaureate and medical degrees at the University of Pittsburgh, he interned at the U.S. Naval Hospital in Philadelphia. Following a five year bout with tuberculosis, he served a residency in medicine at Eagleville Sanatiorium from 1951 to 1954, was chief of the chest department at Philadelphia General Hospital for two years, and medical director of Rush Hospital, Philadelphia from 1955 to 1959.

As medical director of PHICO, he reviews all claims involving 187 insured hospitals and some 4,000 hospital based physicians, including house staff, anesthesiologists, emergency physicians, and other contract and full time physicians.

Five previous articles on risk management in PENNSYLVANIA MEDICINE have stressed statistics and emphasized reducing risks in office practice. This article will concentrate on the importance of physician participation in hospital risk management programs, for the majority of practicing physicians in Pennsylvania have admitting privileges in a hospital. In addition, approximately 80 percent of all claims involving physicians occur in hospitals. When a physician is sued because of a hospital-incurred incident, the hospital also is sued because it is legally responsible to see that physicians are competent and adhere to accepted standards of practice.

Responsibilities

The governing body of a hospital has the ultimate responsibility for overall quality of patient care. It delegates to administration the authority for operation of a well-organized hospital with provision of optimum care in a safe environment. The medical staff is delegated authority and responsibility for assurance of quality of care through its board-approved bylaws, rules, and regulations. The "rugged individualism" so dear to the physician in the office has no place in the hospital where the medical staff, as a group, is held accountable for the actions of its individual members.

What is risk management?

The term "risk management" has been used freely in heavy industry for many years to describe a safety control mechanism. Its recent application to hospitals certainly has not encouraged physician participation: "risk" is threatening and "management" means it's someone else's responsibility! "Injury prevention" or "quality care control" might be more acceptable to physicians.

Risk management is a simple con-

cept that has been made complex through a lack of understanding. The fundamentals of risk management are used by physicians every day through central collection of information (history, physical, lab tests), analysis of data (diagnosis), elimination or minimization of problems (treatment), and prevention.

A risk management program is a systematic, hospital-wide program designed to reduce preventable accidents and injury and to minimize the financial severity of claims.[1] A program which is successful in improving quality of care must have strong commitment from the board, administration, and medical staff. Most incidents occurring in hospitals are known to someone and might already have been reported. All too often the information remains in the initial reporting department or committee and is not known to administration or staff. A central location to which incidents can be reported promptly, without fear of punishment, and from which corrective recommendations can be disseminated must be established.

Incident report

The hospital incident report is the principal reporting and fact-finding tool for any risk management program. An "incident" is any happening that is not consistent with routine operation of the hospital or *any* departure from normal patient care. State and national statistics on numbers of incidents, claims, and settlements could be reported here, but it is more important for physicians to know what kinds of professional and general liability incidents are taking place in their own hospitals. The staff should then ask administration what can be done to help reduce these numbers.

The majority of suits involving both doctors and hospitals are the result of harm done to a patient by diagnostic or therapeutic endeavors. It is difficult to believe that most doctors are not aware of these maloccurrences when they happen. Many physicians, by their own admission, do not see that such reports are initiated. The most common reasons given for not reporting incidents are:

- Reports were never requested before.
- Reporting results in increased claims and premiums.
- Hospitals enjoin physicians in suits.
- Non-reporting means non-discovery.

There is no valid reason for not reporting known incidents, and the reasons given are self-protective rather than patient-protective. If we really believe in quality of care and patient safety, every physician has an obligation to each patient and the admitting hospital to report incidents that cause harm, or could cause harm, to patients. The risks of not reporting far exceed those of reporting.

There have been instances in which physicians have forbidden nurses to initiate an incident report because it is a "complication" and not an incident. The two words are synonymous, but neither is necessarily synonymous with "malpractice." Only about 1 percent of incidents reported develop into claims, and many claims are resolved without a finding of "malpractice." If the incident reported does not develop into a claim, no harm has been done by reporting it, and a useful purpose has been served by exposing the irregularity. If the incident is one which should result in a claim, the failure to report it will not make it disappear, but the lack of knowledge of its existence will seriously affect an investigation and its defense.

The importance of accurate incident reporting is its statistical value in the prevention of future incidents and improvement in patient care; a secondary value is the possibility of reduced malpractice premiums. In return for cooperation in risk management programs, the staff should expect assurances from administration that:

- An early and thorough investigation of claims will be made to determine the merits of allegations and the value of the claim.
- The physician involved in an incident will be kept advised of investigative or settlement procedures.
- Statistical information discovered by incident reports will be used for educational, not punitive, purposes.
- Corrective action involving professional care will be taken through the staff bylaws, rules and regulations, and peer review activities.

Informed consent

Informed consent involves the patient's right to know what may happen to his body before approval for a procedure is given. If it can be shown that a physician did not inform the patient of the nature of the treatment or procedure, the risks, and the alternatives and complications (as required under Act 111), the plaintiff could prevail on the basis of assault and battery—regardless of the presence or absence of a malpractice event.

The standard consent form which patients sign for the hospital's protection does not necessarily prove that a physician properly informed the patient; however, a properly completed form signed by physician and patient can support the defense against a claim of "lack of informed consent." Medical records of patients who allege lack of informed consent usually do not contain documentation that the physician even visited the patient pre-operatively; thus it is the physician's word against the patient's in court—and we know who wins!

For the physician's protection, the chart should show a handwritten, timed and dated notation on the progress notes *or* this information should



'If we really believe in quality of care and patient safety, every physician has an obligation to each patient and the admitting hospital to report incidents that cause harm, or could cause harm, to patients.'

be added to the bottom of the standard consent form. This note should state that the physician gave his patient the information required under Act 111 and obtained the patient's consent. Enumeration of all complications, risks, and alternatives is not necessary; the note may simply state that these were explained.

Discharge information

Some incidents cannot be known to physicians or hospitals because many result from complications that occur after the patient leaves the hospital or emergency department. The attorney's allegation in such suits often is that the physician did not give the patient enough information about self-care at the time of discharge.

We are all aware of studies which have proven that patients have poor retention or understanding of the spoken word pre-operatively. The same applies to discharge information. Thus it is important to continuing patient care that instructions are given to the patient at the time of discharge and are documented in writing by the physician. Most physicians claim this is contained in the dictated discharge summary, as required by JCAH. The *patient,* however, does not receive a copy of the discharge summary. The attending physician is responsible for the patient's care until such time as the patient returns to a clinic or the referring physician.

The patient should be informed in writing about his medication; possible complications; activity; time, date, and place of return visit; and where to call in an emergency. A three-part form could be developed by the staff for this purpose. With such a form an original remains on the record, one copy is given to the patient, and another copy is given to the attending physician. A re-designed front sheet on the chart can accommodate this information.[2]

Conclusion

A recent review of more than 200 professional liability claims involving Pennsylvania physicians (regardless of insurance coverage) and hospitals has led to the conclusion that a properly organized hospital risk management program can result in improved patient care and reduced insurance premiums.

Such a program cannot succeed, however, without physician commitment, for most of the harm to patients is not a result of lack of knowledge or willful negligence, but rather lack of time—to listen to the patient—to examine the patient—and to examine the chart. □

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2. Sample supplied on request by writing to: Medical Director, PO Box 53, Camp Hill, PA 17011.

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Final classification of the less-than-effective indications requires further investigation.

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You could be next . . .

Will hospital-based MDs be the initial step to physician income regulation by the government under the cloak of cost containment? If so, the first groups to be affected will be radiologists, pathologists, anesthesiologists, and some hospital-based cardiologists. If this ground is broken successfully, it will be only a matter of time until more fertile fields are sought. And that means *your fees.*

The Maryland Health Services Cost Review Commission (MHSCRC) has argued successfully in state court that it has the authority to regulate the incomes of pathologists, anesthesiologists, radiologists, and cardiologists because the fees of these MDs are for "hospital-based" services. Radiologists are appealing the decision, along with pathologists and cardiologists of Holy Cross Hospital in Silver Spring, Maryland.

Where did the MHSCRC come from and upon what do they base their authority to do this? Under PL 93-641, the Health Services Planning and Resource Act, five states—Colorado, Connecticut, Maryland, Massachusetts, and Washington—have received federal money to establish these cost review (or rate regulatory) commissions. About two dozen states now have some form of cost review program. Of the five named, only the Maryland Commission thus far has attempted to extend its control to include physicians' fees. If it is successful, other states will follow.

About a year ago, Ralph Nader's Health Research Group (HRG) called on the Carter administration to place all hospital-associated MDs on salary. The HRG estimates, based on a Health Care Financing Administration study, revealed that such a move would have saved about $215 million in 1975. Sidney Wolfe, MD, spokesman for the HRG, in a letter to HEW Secretary Joseph Califano said, "If all the approximately 6,400 hospital-based pathologists, radiologists, and anesthesiologists in the United States had been paid salaries at the average rates shown in the HEW study, instead of being compensated through percentage or fee-for-service arrangements, about $215 million of consumer and taxpayer money would have been saved during fiscal 1975."

Reaction to HRG's position from the professional organizations representing physicians named in the study was pointed. The American College of Radiology disputed HRG's charges, averring that radiologists, as consultants, do not generate charges, and that the majority are on direct billing systems. The College of American Pathologists disputed HRG's assumption that there is a direct relationship between rising hospital costs and reimbursement arrangements for hospital-associated MDs. The American Society of Anesthesiologists stated that about 90 percent of anesthesiologists are on fee-for-service direct billing and 8 percent are on salary. ASA wondered who was being compensated by percentage contracts.

Is there a need for government controls on fees? Will cost review agencies concern themselves *only* with percentage contract arrangements? Do direct billing MDs have any effect on rising hospital costs even when they are hospital-based? Will a salary with all the fringe benefits be any more economical?

Will MDs who might fall under these regulations remain hospital-based or will there be an exodus from hospital-based practice? If such a move occurs, will it contribute to or detract from quality patient care? Will fees of the individual private practitioner next be scrutinized by government cost review?

The American College of Radiology has elected to contest MHSCRC's position in court. They believe that this is a "must win" situation for themselves and others and they are providing support to Maryland radiologists from ACR's legal fund. The outcome of this test case is a vital issue to every practicing physician. A "win" for MHSCRC is a "loss" for you.

Looking back over this editorial, I am reminded of the motto which appears on a local weekly newspaper—Insist on justice for your fellow man . . . you could be next.

David A. Smith, MD
Medical Editor



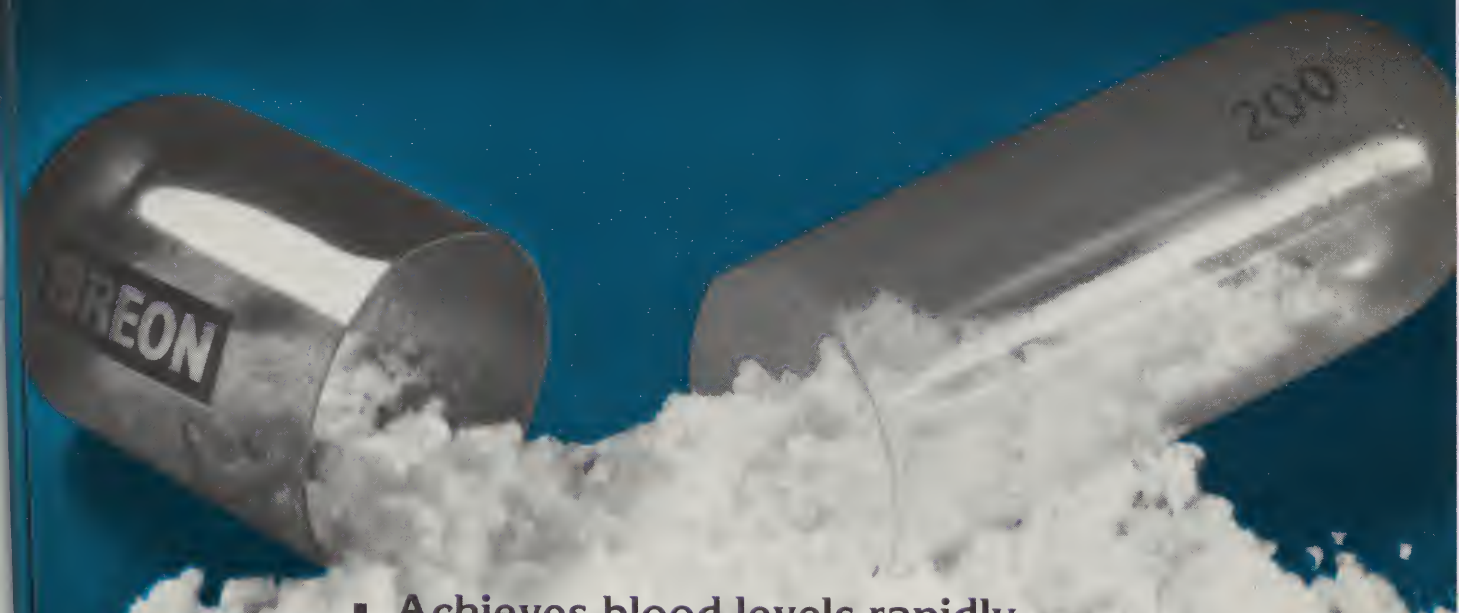
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CONTRAINDICATIONS: Bronkodyl is contraindicated in persons known to have had serious idiosyncratic responses to theophylline, its salts, or the other methylxanthines, theobromine, or caffeine and may be contraindicated in peptic ulcer.

WARNINGS: All methylxanthines should be used with caution in children and in others who are currently taking bronchodilator products, especially in rectal dosage form, which may contain theophylline or related drugs.

USAGE IN PREGNANCY: Although theophylline has been used for many years, with no evidence of adverse fetal effect or teratogenicity, its safety in pregnancy has not been established. Therefore use of Bronkodyl during lactation or in women of childbearing potential requires that possible benefits of the drug be weighed against possible hazards to fetus or child.

PRECAUTIONS: Bronkodyl should be used with caution in patients with cardiac or circulatory disease.

ADVERSE REACTIONS: Gastrointestinal: Epigastric distress, nausea, vomiting. Cardiovascular: palpitations. CNS: Insomnia, restlessness, irritability, convulsion.

DOSAGE AND ADMINISTRATION: Adults: Usual dosage of Bronkodyl is 200 mg. every 6 hours (four doses in each 24 hours). This dosage may be adjusted to reflect individual clinical response as an indication of slow or rapid metabolism of the drug. If adverse reactions are encountered, each dose may be reduced, or the interval between doses may be lengthened, or both. If clinical response is not satisfactory, indicating possible rapid inactivation of the drug, dosage may be gradually increased to achieve the desired response. In some instances of either too slow or too rapid metabolism, plasma levels of theophylline should be determined and dosage adjusted accordingly to achieve levels above 10 mcg/ml, but not to exceed 20 mcg/ml.

Dosage in Children: Usual dosage should be based on administration of 10 mg per kg per 24 hours, divided in 4 doses per day, given every 6 hours. As this may not be possible with use of the capsules, Bronkodyl elixir may be used. Theophylline saliva levels (approximately 60% of simultaneous blood levels), may facilitate dosage adjustments, especially in children, to obtain appropriate response.

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practice management

Why not own your telephone equipment too?

Leif C. Beck, LL.B., CPBC
Vasilios J. Kalogredis, J.D.

In the past, almost everyone presumed that only the "Bell System" could satisfy telephone needs. Until recently, it could hardly be contested.

But the government has taken extensive measures to strike down "Ma Bell's" virtual monopoly on telephone equipment. For example, in June 1978 the Federal Communications Commission ruled that a private telephone system owner no longer had to pay the telephone company's monthly charge for its coupling device. The device was intended to protect the telephone network nationally from potentially harmful private telephone equipment. The Commission's ruling resulted in savings as high as $13 per line per month.

This ruling makes real cost savings feasible to telephone equipment owners. As economy conscious physicians you should seriously investigate and consider the equipment alternatives to "Ma Bell."

Greater numbers of phone users are switching to telephone ownership. Although ownership does not suit everyone's needs, physicians should evaluate the issue objectively.

Generally, the sellers of the private telephone systems (known as interconnect companies) are much better from a cost standpoint. Each monthly telephone bill contains significant charges simply for the equipment use (for each telephone, button, line, etc.). These "rental" charges typically appear as the first line of the monthly bill's charge summary. You can eliminate that line by buying your office's telephone hardware from an interconnect company.

The savings can be substantial. We recently compared the cost of purchasing against the Bell System's monthly equipment charges. Our monthly Bell equipment charges totaled $265. Borrowed funds could purchase comparable equipment from an independent telephone supplier. With a twelve percent interest, five year loan from a bank, we would pay $150 per month. After five years the note would be paid off and $265 per month (which ignores probable Bell increases) would be saved. Yearly the savings total $3,200. Savings such as this must be considered seriously.

One argument to discourage private ownership emphasizes the possibility that telephone equipment may become obsolete. We feel that is generally a weak argument, when compared to the dramatic cost savings usually involved. After all, what bene-

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fit (asset-wise) does one get by paying Ma Bell's monthly "rent" bills?

Also, reduced telephone bills are not the only dollar advantages to the purchaser. An owner can depreciate the equipment and take the valuable ten percent investment tax credit on it. The credit can be a significant advantage to high tax-bracketted physicians.

It is important that a physician seek out several interconnect companies in his geographic area. They usually can be found in the Yellow Pages under Telephone Equipment and Systems. One might also seek leads from his management consultant, attorney or accountant.

Many large and reputable firms are in the field. Some companies that have been involved in telecommunications for years can provide extensive lists of local health care practices using their equipment. Others are opportunists, mere fledglings into a new growth business in an extremely competitive market where an unsound company can easily and quickly fail. Be sure to have the credentials of a prospective supplier closely scrutinized before becoming involved.

Another major consideration in switching to an interconnect company's system is service: Who will provide it? The Bell System is obligated to continue full line service and connection to privately purchased equipment.

Private owners may fear that "Ma Bell" would not be so cooperative when dealing with the equipment in their offices. The Government prohibits Bell from such discriminating practices. In the past fears may have been legitimate but generally, service no longer poses a problem.

The Bell System usually provides excellent service—both in terms of personnel and parts. Bell's quality is difficult for interconnect companies to equal. Check the interconnect suppliers' references; critically explore and evaluate their service departments.

A practice which is not located in a large metropolitan area may pose a serious problem. Private owners should know where the nearest service center is and how well it is staffed. For example, many interconnect companies may not be able to guarantee prompt (within two hours) emergency service in Wellsboro, although they could in Philadelphia.

In evaluating a company's service, have its maintenance contract closely reviewed (ideally by one's advisors). Established companies tend to offer a five-year maintenance agreement. The first year is usually free; the other years are prorated. A system we recently reviewed called for a $1.75 per unit per month maintenance fee for the second through fifth years.

The problem of a possible breakdown in a private phone system may not be so dramatic an experience. The telephone company is required to provide one of its phones for every line brought into the office. When a private phone system does break down, there is the security that Bell phones will back it up temporarily.

Also, be sure any contract clarifies what is promised in writing. For example, if two hour service is guaranteed for emergencies, be sure "emergencies" are satisfactorily defined.

Physicians should get assurances from the interconnect company that switchover from Bell equipment to owned equipment will not disrupt office hours. A well coordinated switch should only take a few hours during nonpeak telephone periods, perhaps on a weekend.

Physicians should be sure to select a system to suit their needs. A conservative forecast of growth should be anticipated. Ideally, you should seek an expandable system but be wary of overbuying. Remember, you are dealing with salesmen.

In conclusion, unless you are a physician who is planning to retire in a few years, you should have the question "Should I buy my telephones?" critically evaluated.

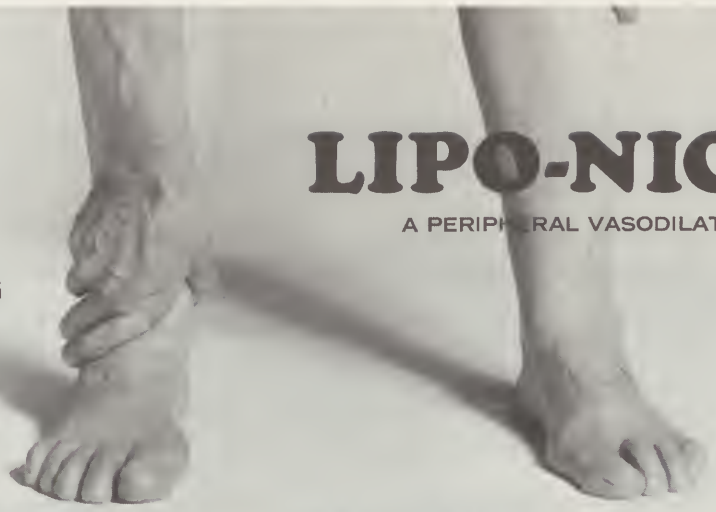
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Treatment of severe hypertension

Alvin P. Shapiro, MD
Yehuda M. Traub, MD

The definition of severe hypertension can be controversial. We have chosen an empirical one: a consistent elevation of the diastolic blood pressure (BP) of higher than 115-120 mm Hg (or > 105-110 mm Hg in persons under 20 years old), with or without end-organ damage. This definition might include hypertensive patients who, although presenting with a BP which is somewhat lower, have end-organ involvement directly attributable to high BP. While emergency situations related to hypertension (such as malignant hypertension, hypertensive encephalopathy, dissecting aortic aneurysm, etc.) also represent severe hypertension, they are beyond the scope of this article, which is aimed at the chronic management of severely hypertensive patients.

The benefits of lowering BP became evident relatively early in the study of severe hypertension. As many as twenty years ago, studies showed that mortality rates could be reduced and vascular changes of malignant hypertension could be reversed by effective treatment.[1,2] Malignant hypertension, however, has a different pathology than benign essential hypertension, in which damage progresses much more slowly.[3]

In patients with moderately severe benign hypertension (diastolic BP 115-129 mm Hg), the favorable effect of treatment was proved more recently by the Veterans Administration Cooperative Study.[4] In this study, the difference between the actively treated and placebo-"treated" groups was so striking that the investigation was terminated after 18 months rather than five years as originally designed.

All actively treated patients in the Veterans Administration study were given combinations of hydrochlorothiazide, reserpine, and hydralazine.[4] Other investigators have advocated a more sophisticated approach in attempts to tailor certain drugs to certain specific characteristics of individual patients.[5–7] Such an approach may be of doubtful practical yield and too time-consuming and expensive for routine application.

Nevertheless, patients with severe hypertension (especially those who are young and/or have diastolic BP > 130 mm Hg) should have a more thorough workup than generally recommended for milder degrees of hypertension because special causes of hypertension, some of them surgically correctable, and end-organ damage are more prevalent in such patients. Workup should include, in addition to urinalysis, hematocrit, serum potassium, creatinine or BUN concentration and ECG,[7,8] a 24-hour urine collection for Vanilmandelic Acid (V.M.A.) and a rapid sequence intravenous urogram. More complex diagnostic procedures should be reserved for those subjects in whom physical examination and/or laboratory tests suggest a specific cause of hypertension or for whom conservative drug therapy proves unsatisfactory.

Otherwise, the principles of chronic management for patients with severe hypertension should be the same as for any hypertensives, and should be based on:

1. Good documentation of BP evaluation by at least two measurements on two occasions a few days apart, unless an emergency situation is suggested by papilledema, convulsions, or other abnormal findings.

2. Smooth and gradual reduction of BP to avoid adverse effects and achieve better patient compliance. We recommend a stepped-care approach, such as the one suggested by the Report of the Joint National Committee on Detection, Evaluation, and Treatment of High Blood Pressure,[8] although many patients in this group will end up on a number of antihypertensive agents. Our experience has shown that a fair percentage of severely hypertensive subjects will come under control (i.e., diastolic BP ≤ 90 mm Hg or less) when given a thiazide diuretic alone or in combination with a relatively small amount of reserpine, propranolol, or methyldopa.

3. Modifications in antihypertensive therapy based primarily on repeated BP measurements rather than on the patient's symptoms, which may be absent or non-specific unless related to side effects of the drugs. Such modifications also should be made smoothly; therapy should never be discontinued abruptly.

4. Adjustment of chronic antihypertensive therapy even for severe hypertensives in ambulatory rather than hospital settings, in which environmental conditions may be entirely different.

5. Application of nonpharmacologic measures generally rec-

This article is the third in a series presented in cooperation with the hypertension control program of the Pennsylvania Department of Health and the American Heart Association, Pennsylvania Affiliate. Dr. Shapiro is professor and acting chairman of medicine at the University of Pittsburgh School of Medicine. Dr. Traub is assistant professor of medicine at the university.

ommended in the management of hypertension (such as controlling obesity and excessive sodium intake, physical exercise, possible behavioral adjustments, etc.).[7] Although these measures play a complementary role, they cannot replace pharmacologic therapy in severe hypertension.

Most patients with severe hypertension will respond favorably to the treatment outlined above.[8] A minority, however, may be unresponsive to conventional management. Such patients may need further diagnostic workup, preferably in a specialized hypertension unit in which some also may benefit from potent investigational drugs, such as minoxidil, labetalol, guanabenz, and bethanidine. Others may need large doses of furosemide or dialysis when elevated BP is related to excessive fluid retention because of renal failure. The BP of some patients with renal failure (fortunately a small minority) can be reduced only by bilateral nephrectomy. A decision for such heroic measures should be made only in highly specialized centers.

Whatever therapeutic measures are taken, it should be remembered that hypertension is a "lifetime" disorder. Success in therapy requires life style adjustments and acceptance of a therapeutic regimen. Education of the patient, along with reassurance and support, are vital components of overall medical management. □

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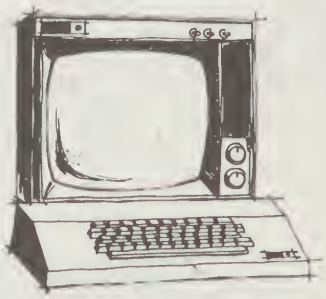
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Survey results

Use of explosive anesthetic agents in hospitals

Maciej Babinski, MD
R. Brian Smith, MD

Dr. Babinski is an assistant professor of anesthesiology at the University of Pittsburgh School of Medicine. Dr. Smith is professor and vice chairman of anesthesiology and anesthesiologist-in-chief at the Presbyterian-University Hospital of Pittsburgh.

A 1972 survey of Pennsylvania hospitals (R.B. Smith, The use of explosive anesthetic agents, PENNSYLVANIA MEDICINE 75:55-56, 1972) determined that two explosive anesthetic agents, ether and cyclopropane, were used in 56 percent of participating hospitals. Four years later, in 1976, a similar survey of these hospitals was conducted to determine changing trends in the use of explosive anesthetic agents.

Our 1976 survey was conducted in the same manner as the 1972 survey. We obtained a list of all Pennsylvania hospitals with operating rooms from the 1975 edition of the *Journal of the American Hospital Association*.

Of 255 questionnaires sent to hospital administrators, we received 243 completed questionnaires, a 95 percent response rate. The distribution of usage of explosive anesthetic agents in obstetrics and EENT surgery is shown in Tables 1 and 2, respectively; Table 3 presents a general summary.

In the Pennsylvania hospitals surveyed the use of explosive anesthetic agents decreased: in 1972, ether and cyclopropane were used in 56 percent of participating hospitals as compared with only 27 percent in 1976.

Sixty-nine Pennsylvania hospitals discontinued use of explosive anesthetic agents. A follow-up questionnaire was sent to these hospitals requesting the reason(s) for this practice. Fifty-seven hospitals completed and returned the questionnaires, rendering an 82.6 percent response rate. Table 4 presents the results of this questionnaire.

The frequency rate for use of explosive anesthetic agents was not ascertained because many hospitals do not keep these statistics. Many hospitals indicated that occasional use of explosive anesthetic agents necessitates additional expenses for safety precautions in operating rooms.

Philadelphia and Allegheny County area hospitals showed a decline in the use of explosive anesthetic agents. The greatest percentage of use of these agents in Pennsylvania is, however, in Philadelphia County.

Survey results also show that ether is more commonly used for EENT surgery and cyclopropane for obstetrics.

It should be noted that many anesthesiologists probably are trained in institutions in which explosive agents are no longer used. □

TABLE 1
Number of Hospitals Using Explosive Agents for Obstetrics

Agent	*Pennsylvania*	*Allegheny County*	*Philadelphia County*
Ether	5/243 2% (13%)*	2/29 7% (17%)	1/39 3% (18%)
Cyclopropane	27/243 11% (29%)	4/29 14% (38%)	6/39 15% (44%)

*1972 survey results are in parentheses.

TABLE 2
Number of Hospitals Using Explosive Agents for EENT

Agent	*Pennsylvania*	*Allegheny County*	*Philadelphia County*
Ether	24/243 10%	6/29 21%	7/39 18%
Cyclopropane	11/243 5%	2/29 7%	4/39 10%

TABLE 3
Number of Hospitals Using Explosive Agents

	Questionnaire Completed	*Use Cyclopropane*	*Use Ether*
Pennsylvania	243/255 95%	28/243 12% (16%)*	12/243 5% (13%)
Allegheny County	29/29 100%	1/29 3% (17%)	2/29 7% (17%)
Philadelphia County	39/43 91%	5/39 13% (16%)	1/39 3% (8%)

	Use Ether and Cyclopropane	*Use Ether and/or Cyclopropane*	*Use Neither*
Pennsylvania	25/243 10% (28%)	65/243 27% (56%)	178/243 73% (43%)
Allegheny County	4/29 14% (38%)	7/29 24% (72%)	22/29 76% (28%)
Philadelphia County	8/39 21% (44%)	14/39 36% (68%)	25/39 64% (32%)

*1972 survey results are in parentheses.

TABLE 4
Reasons for Discontinuing Use of Explosive Anesthetic Agents

	# of hospitals
Risk of explosion	40
Medical-legal reasons	32
Preference of anesthesiologists	24
Cost reduction	8
Others	10
Total	57

Case report

Nasal septum carcinoma: excision and reconstruction

Nae H. Park, MD

Inadequate treatment and fear of the resulting nasal deformity have been major causes of recurring nasal cancers. Surgeons with the knowledge of reconstruction techniques which minimize the defect should not compromise the principle of wide local excision in the treatment of carcinoma of the nasal septum and vestibule. The case described illustrates the use of one such technique—the alar sulcus incision and the nasolabial flap—to reconstruct a nose after surgical removal of a carcinoma involving the nasal septum and vestibule.

Case report

A 67-year-old male presented with crusting and bleeding from a 1.5 x 2 cm ulcerated lesion involving the left side of the caudal end of his nasal septum, extending into the left nasal vestibule. The lesion had grown slowly for five years despite many attempts to control it with both chemical and electro-cauterization. Biopsy showed a well differentiated squamous cell carcinoma, and the patient was admitted for definitive surgical extirpation.

Adequate exposure was obtained with an incision through the left alar sulcus (Figs. 1A and 1B). The left half of the columella, including the medial crus of the left alar cartilage, was excised along with a full thickness portion of caudal septum and a margin of vestibular mucosa surrounding the lesion.

A left nasolabial flap measuring 4 × 1.5 cm was then fashioned with its distal tip sutured to the remaining columella and its mid-portion used to line the nasal vestibule. The lower portion of the alar sulcus incision was sutured, leaving a "tunnel" superiorly through which the nasolabial flap passed (Figs. 2A and 2B).

Six weeks later, the nasolabial flap was transected at the point where it entered this tunnel, a small amount of de-fatting was performed, and the upper portion of the alar sulcus incision was sutured. The patient was left with a 1-cm square septal perforation which may be reparable in the future should bothersome crusting develop.

After six months, the cosmetic result remained good; the remaining right medial crus provided sufficient tip support (Fig. 3). There was no evidence of recurrent tumor in either nasal cavity.

Discussion

This case illustrates several important points. First, the patient received inadequate initial treatment for his disease, probably due to a desire to minimize or avoid a cosmetic deformity. Thus time was lost and the lesion grew; the wide local excision, the treatment of choice, became more difficult.[1, 2]

Second, when using a nasolabial flap for immediate reconstruction the morbidity and deformity resulting from surgical treatment are much less than one might expect. In our patient, whose lesion did not involve the entire columella, the final appearance of the nose is virtually normal.

Local flaps are preferable to free skin grafts, which contract when used to line the parts of the nasal cavity.[3] The nasolabial flap is a natural choice; it is close to the defect and has a good blood supply (angular artery and branches of the infraorbital).[4] The alar sulcus incision which is necessary to adequately expose the tumor's extent simultaneously outlines the medial border of the flap. After closure of the donor site the final scar lies inconspicuously in the nasolabial fold.

Nasolabial flaps can be used in a variety of ways to reconstruct all parts of the nose including the regions of the tip alae and bridge.[5-10] Of most immediate concern for our patient, however, were defects of the columella, septum, and vestibular lining. The entire columella may be reconstructed using a

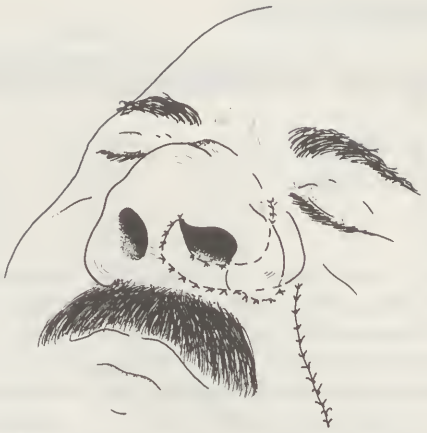


Figures 1A and 1B. **The tumor involving left caudal septum, extending into the vestibule, exposed adequately by the left alar sulcus incision.**



Dr. Park practices otolaryngology in Harrisburg and is on the staffs of the Polyclinic Medical Center in Harrisburg and Holy Spirit Hospital in Camp Hill.





Figures 2A and 2B. **The superiorly based left nasolabial flap rotated medially with distal portion sutured to the remaining columella and mid-portion lined the vestibule. The lower portion of the alar sulcus incision sutured in the normal position, leaving a "tunnel" superiorly through which the nasolabial flap passed.**



Figure 3. **The cosmetic result is good after six months.**

single nasolabial flap with the distal portion folded on itself[11] or lined with a free skin graft.[12] Bilateral nasolabial flaps may be used and sutured back to back.[13] The latter technique provides the most skin to cover defects of the vestibule and septum created by resection of the tumor.

Nasolabial flaps may be brought to the site of the defect in a variety of ways. Champion described a multistage procedure in which the free end of an inferiorly based flap is sutured to a de-epithelialized area destined to be the base of the new columella.[14] After a suitable delay the original base of the flap is freed, rotated, and sutured to the nasal tip area.

Vistnes' method used bilateral superiorly based nasolabial flaps which were brought to the remaining columella skin under the transected lateral margins of the alae. Two months later, the flaps were replaced and the alae re-sutured to their normal anatomic position.

Our own method is based on the "superior nasolabial tunnel flap" described by DaSilva and Georgiade.[15] A superiorly based flap is brought through the upper portion of the alar sulcus to the columellar area. The lower lateral and inferior border of the ala may immediately be re-sutured to its normal anatomic position without compromising the blood supply to the pedicle. The advantages of this method include:

- Using the most direct route and eliminating excessive twisting of the flap;
- Minimizing the length of the flap; and
- Avoiding the inclusion of hair bearing lip skin.

Since most of the pedicle is inside the nose, the immediate cosmetic effect is good and the subsequent defatting and division of the pedicle is a small procedure. □

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Comparative study

Surgical treatment of breast cancer, 1968 and 1973

Roscoe W. Teahan, MD
Hugh R. Gilmore, MD

Today, more than ever before, physicians disagree about the proper treatment of breast cancer. Halsted[1] described the radical operation for breast cancer in 1894 and, except for modifications, notably by Urban[2] and Haagenson,[3] his has been the standard procedure for operable breast cancer ever since. The operation is laborious and time-consuming, the resulting deformity appreciable, and the results often disappointing. Many question seriously whether there is some better way of treating this disease. Two alternatives now exist: (1) a less than thorough operation, especially regarding axillary dissection; and (2) a much restricted operation.

The restricted operation has been advocated for some ten years by George Crile, MD, of Cleveland.[4] He has recommended less extensive surgery, and in some instances has removed only the lump containing the cancer.

An axiom concerning the successful treatment of cancer is: when all cancer cells are removed the patient is cured. Many believe there is a time in the life of most breast cancers when all diseased cells are contained in one small circumscribed area and, under such circumstances, surgery cures. Others believe a recognizable breast cancer is seldom so localized.

Dr. Teahan is an associate in surgery at Germantown Hospital, Philadelphia, and the 1975 president of the Wainwright Tumor Clinic Association of Pennsylvania. Dr. Gilmore is a consultant for the Cancer Control Section of the Pennsylvania Department of Health. *The authors gratefully acknowledge the cooperation of hospital tumor registrars in compiling these data and the assistance of Krishnan Ramaswamy, Pennsylvania Department of Health, for performing a statistical analysis.*

In an effort to determine current surgical practices comparative data concerning breast operations performed in 86 Pennsylvania hospitals were studied for the years 1968 and 1973. The survey was a cooperative effort of the Wainwright Tumor Clinic Association of Pennsylvania and the Cancer Control Section of the Pennsylvania Department of Health.

Hospital tumor registrars at participating hospitals were requested to provide information on breast cancer patients treated by surgery in 1968 and 1973. Information requested included the operative procedure used, the stage of the disease, and the age group.

Operative procedures were classified as indicated:

- *Partial*—Removal of the tumor without removal of the entire breast, also referred to as "lumpectomy" or tylectomy. International Classification of Diseases (ICDA) operation code number 65.2.
- *Simple*—Removal of the entire breast including the axillary tail. Axillary nodes and pectoral muscles are *not* removed. Also referred to as total or complete mastectomy. ICDA operation code number 65.3.
- *Modified radical*—Removal of the breast, the pectoralis minor, and the axillary nodes. The pectoralis major is left intact. The overlying fascia may or may not be removed. ICDA operative code number 65.4.
- *Radical*—Removal of the breast, axillary nodes, and pectoralis major and minor muscles. ICDA operation code number 65.5
- *Extended radical*—Removal of the breast, the pectoralis major and minor, and the axillary and internal mammary nodes. This is also known as the Urban operation. ICDA operation code number 65.6.

Stage was classified as:

- *Localized*—The tumor is confined to the breast.
- *Regional spread*—The tumor has spread to the skin, pectoral muscles, chest wall or to the axillary, infraclavicular, internal mammary (parasternal), or pectoral (Potter's) lymph nodes.
- *Remote spread*—The tumor has spread to distant organs or lymph nodes, such as to the opposite breast, bones, ovary, supraclavicular lymph nodes, etc.

Of the 244 general hospitals in Pennsylvania, 86, or 35 percent, participated in this study. These 86 hospitals reported 2363 operations for breast cancer in 1968 and 2900 in 1973, giving a total of 5263.

Survey results

Table 1 shows the total operations for each year and the types of operations. There were 537 more operations reported in 1973 than in 1968. The radical operation was performed most often in both years. Table 2 shows the percentage of various operations used in each year and the change between 1968 and 1973.

As might be expected, most of the partial and simple operations were on cases showing no clinical evidence of spread beyond the breast (localized). In the two years combined, 63.3 percent of the 248 partial operations and 63.6 percent of the 966 simple operations were on localized cases. Surprisingly, 23.4 percent of partial operations had remote spread. Perhaps these were patients considered poor risks for more extensive surgery.

The stage of disease in patients having the modified radical or radical operation in the two years was divided about equally between localized and regional. Of the modified radical operations, 48.7 percent were on patients with localized disease and 45.3 percent had regional spread; 50.0 percent

of the radical operations were on localized cases and 45.6 percent were on regional spread cases.

Only 19 extended radical operations were performed. Eight of these were on patients with localized disease and 10 were on regional cases. Only one patient had remote disease.

The stage of the disease varied little in the two years. In 1968, 50.8 percent of cases were localized, as compared with 54.3 percent in 1973. In 1968, 42.7 percent were regional as compared with 39.2 percent in 1973. Remote cases comprised 6.5 percent in both years.

The age group distribution of cases was comparable to that reported in the third National Cancer Survey[5] and there was little variation between 1968 and 1973 (Table 3).

TABLE 1
Number of Operations for Breast Cancer, All Stages (1968 and 1973)

	Partial	*Simple*	*Modified radical*	*Radical*	*Extended radical*	*Total*
1968	86	429	312	1,524	12	2,363
1973	162	537	1,015	1,179	7	2,900
1968 & 1973	248	966	1,327	2,703	19	5,263

TABLE 2
Percentage of Operations for Breast Cancer, All Stages (1968 and 1973)

	Partial	*Simple*	*Modified radical*	*Radical*	*Extended radical*	*Total*
1968	3.6	18.2	13.2	64.5	0.5	100.0
1973	5.6	18.5	35.0	40.7	0.2	100.0
Percentage change	+55.6	+1.6	+165.2	−36.9	−60.0	

TABLE 3
Distribution of Breast Cancer by Age Group (%)

Age group	*20-39*	*40-59*	*60-79*	*80 and Over*
Study group				
1968	6.5	47.9	38.9	6.7
1973	6.2	44.6	41.3	7.9
1968 & 1973	6.3	46.1	40.2	7.4
Third National Cancer Survey				
1969 - 1971	6.6	45.1	39.6	8.6

Discussion

Comparison of the operations for breast cancer in 1968 and 1973 shows that in both years the radical operation was most frequently used. While the relative proportion of modified radical operations increased 165 percent in 1973, the relative proportion of radical operations decreased 37 percent. An increase of only 1.6 percent marked the change in the relative proportion of simple operations. Partial operations increased 56 percent, but their number was small (248 in the two years combined) compared with 5263 total operations. The extended radical operation decreased 60 percent, but only 19 were performed in the two years combined.

In 1968 one of the larger hospitals divided almost equally the number of radical between radical and modified radical procedures in its 35 patients. In 1973 the hospital reported one radical and 46 modified radical operations in its 47 patients.

Another smaller hospital in 1968 reported three radicals, six modified radicals, and six simple mastectomies. In 1973 it reported no radicals, six modified radicals, and nine simple mastectomies.

One teaching hospital in 1968 reported that 91 percent of its patients had a radical or modified radical operation. In 1973, 53.8 percent of its patients had either a simple mastectomy or a partial operation. In another teaching hospital simple mastectomies were done in 45 percent of cases in 1968. In 1973 the figure had increased to 63.9 percent. This is the largest percentage of simple mastectomies except for one small hospital in which only three breast operations were performed during the year.

It is encouraging that in both years a comparatively small percentage (6.5) of cases were staged as remote. There was a modest increase in the percentage of localized cases (50.8 in 1968 and 54.3 in 1973) and a decrease in the percentage of regional cases (42.7 in 1968 and 39.2 in 1973).

Summary

It is apparent that there has been a swing in Pennsylvania from the standard radical breast operation to the less radical operation. Surgeons perform fewer partial and extended radical operations.

Our study showed that the operations most frequently used are the radical and modified radical, but the trend is toward more frequent use of the modified radical and less frequent use of the radical operation. Current surgical practices seem to advocate a more limited operation for breast cancer. □

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Survey results

Occupational medicine in Dauphin County

Warren W. Brubaker, MD
R. Keith Whiting, MD
Felix Glauser, MD

The Subcommittee on Industrial Health of the Dauphin County Medical Society completed a survey of the industries of Dauphin County. Our objectives were:

(1) To determine how occupational health services are provided in our community
(2) To define what occupational or other types of health or allied health services the industries may be interested in obtaining
(3) To stimulate interest in occupational health among our members and in the industrial community.

The Board of Governors approved a questionnaire which was mailed to 42 of the largest industrial organizations in Dauphin County in June 1976. Twenty-five firms responded.

The following report discloses the tabulated results of that survey and the committee's conclusions on the basis of the data.

Question 1. It is apparent from responses received that the majority of occupational health services are provided by nurses. Our respondents indicate that they employ 32 nurses at nine separate locations. Of the four full-time physicians, three are at plants and one serves a hospital.

Question 2. Occupational injuries have been with us for a long time, and a quite adequate system for handling them has evolved. It is apparent that physicians handling occupational injuries do not contribute to prolonged absences from work, and communicate with management regarding the employe work capability.

Question 3. Pre-employment exams are easily available and are judged valuable by 64 percent of the responding industries. Audiometric exams were done by the six larger companies.

The authors are members of the Subcommittee on Industrial Health of the Dauphin County Medical Society. Dr. Brubaker is chairman of the subcommittee.

Question 4. Periodic physical exams of executives are used by almost half the responding group. We believe industries should consider extending periodic examinations to all employes, especially for the detection of hypertension and coronary risk factors.

It is difficult to appraise the responses to parts A, B, C and D of this question because we were unable to determine the need of such exams by each of those who answered.

Question 5. There is an awareness and appreciation of the potential problems posed by dust, fumes, noise, chemicals, and safety hazards. We conclude that industry is monitoring personnel for evidence of illness due to these factors.

Question 6. Many of the larger industries responded "No" to this question because they are already self-sufficient in these areas.

There is an apparent need for this type of service in our community; as government regulations become more numerous this need will probably increase. County medical societies should be prepared to refer an industry requesting such services to an appropriate consultant.

Question 7. Most large industries have hearing conservation and alcohol/drug abuse programs and believe them to be useful. Physicians serving industry should be familiar with such programs and cooperate with management in initiating them.

Question 8. Question 8 evoked some comments. One large industry replied: "Absenteeism is a major problem in industry today. Many physicians will not give information concerning an employee, and thus we cannot effectively control the problem. Doctors' certificates seem to be too easy to obtain. Any help or advice in this area would be greatly appreciated."

The Committee acknowledges that some physicians shun this problem. We make the following suggestions:

- Industrial management and insurers are entitled to an accurate and timely report of a patient's work capability. Medical confidences need not be disclosed. The physician must be responsible, however, for refusing a request for continued sick leave when the patient's physical condition does not necessitate such action.
- When the physician questions the character of the work to which the patient is to return, and/or is concerned about the patient's ability to do this work without harm to himself, he should contact his patient's plant supervisor and obtain an accurate description of the job.
- Many industries have industrial medical departments staffed by full- or part-time physicians who are familiar with the work environment. They can provide job descriptions, and sometimes may arrange special work assignments. Practicing physicians should communicate with these departments for the benefit of their patients.
- Certification of disability or limited work capability is the responsibility of the physician, not his nurse or secretary.

Community physicians should recognize that increased insurance and absenteeism costs are invariably reflected in greater costs of products and services. These costs also are borne indirectly by conscientious workers who are *not* abusing the system.

Occupational health services are provided principally by nurses, with minimal direction by physicians in many instances. Pre-employment examinations and treatment of occupational injuries are being provided to the satisfaction of industry.

Industry has indicated an interest in consultation services in industrial hygiene, toxicology, and occupational medicine. Hearing conservation and alcoholism management programs need leadership and development.

Absenteeism is a major concern of industry and a problem which physicians must regard seriously. Better communication between physicians and industry will certainly benefit patients. □

Question 1. General —

A. Number of employes — Under 25
25 - 100
100 - 250 — 7
250 - 500 — 7
500 - 1000 — 5
Over 1000 — 6

B. Do you have an in-plant medical facility — Yes: 11
No: 14

C. Do you employ a plant physician — No: 17
Full-time: 4
Part-time: 4

D. Do you employ an industrial nurse — No: 14
Part-time: 5
Full-time: 5

Number of Nurses: 32 at 9 separate locations

Question 2. Occupational Injuries and Illnesses —

A. Have you found medical services for the treatment of occupational illnesses and injuries
1. Easy to obtain — Yes: 22
No: 1
2. Of satisfactory quality — Yes: 20
No: 0
3. Reasonably priced — Yes: 15
No: 2
4. Resulted in the employe returning to work within a reasonable period of time — Yes: 17
No: 1

B. Are such services provided at
1. Private physician's office — 16
2. Plant dispensary — 6
3. Hospital — 21

C. Have you been able to "communicate" with the physician
Regarding the employee's return to restricted (limited) work — 22
The progress of the treatment — 20
The prognosis — 19

Question 3. Pre-placement: Pre-employment exams

A. Does your company require pre-employment exams — Yes: 16
No: 9

B. Has your organization been able
1. To have them performed at the desired times — Yes: 17
No: 0
2. Have they been done at a reasonable cost — Yes: 17
No: 0

C. Have the reports been of value — Yes: 17
No: 0

D. Does the exam include special tests such as
Chest x-rays — Yes: 5
No: 9
Audiometric (hearing) — Yes: 6
No: 9
Tbc skin tests — Yes: 4
No: 9
Other — Yes: 4
No: 2

Question 4. Do you periodically (e.g., yearly) examine

A. Food handlers— Yes: 6
No: 3

B. Truck drivers (I.C.C.) — Yes: 6
No: 7

C. Crane operators — Yes: 3
No: 6

D. Workers who are exposed to hazardous substances — Yes: 7
No: 8

E. Executives — Yes: 12
No: 10

F. Hourly workers — Yes: 1
No: 19

Question 5. Have you had industrial hygiene surveys at your location to measure

A. Dusts — Yes: 9
No: 13

B. Fumes — Yes: 12
No: 9

C. Noise — Yes: 13
No: 8

D. Chemical exposures — Yes: 10
No: 12

E. Safety hazards — Yes: 16
No: 7

F. Others

Question 6. Would you welcome the availability of consultation services in:

A. Industrial Hygiene — Yes: 7
No: 8

B. Toxicology — Yes: 7
No: 7

C. Occupational medicine — Yes: 7
No: 8

Question 7. Do you have a

A. Hearing conservation program — Yes: 8
No: 8

B. Alcoholism/drug abuse program — Yes: 6
No: 11

Do you have need of such programs — Yes: 11
No: 11

Question 8.

Do you have a method for obtaining medical opinions in case of absenteeism — Yes: 18
No: 7

Is a mechanism for obtaining such medical opinion necessary — Yes: 13
No: 8

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obituaries

• Indicates membership in the Pennsylvania Society at time of death.

• **M. Harlan Cloud,** Uniontown; University of Pennsylvania School of Medicine, 1924; age 80; died August 28, 1978. Dr. Cloud had practiced medicine in Uniontown for more than 50 years and had been honored with a State Society 50-Year Award. He had been a member of the Uniontown Hospital staff and was county director of the state Department of Health.

• **William T. Corey,** Johnstown; Hahnemann Medical College, 1940; age 65; died August 19, 1978. He had been chief of surgery at Lee Hospital in Johnstown.

• **Gilman E. Heggestad,** Newtown Square; University of Wisconsin School of Medicine, 1945; age 59; died August 26, 1978. Dr. Heggestad was director of surgery at Bryn Mawr Hospital. He had served as clinical associate professor of surgery at Jefferson Medical College and was a consultant at the Veterans Administration Hospital in Wilmington.

• **Albert J. Ingham,** Riviera Beach, Florida; University of Pittsburgh School of Medicine, 1932; age 71; died September 9, 1978. He had served as president of the Venango County Medical Society and president of the staff of Titusville Hospital.

• **C. Harold Kistler,** Ardmore; Hahnemann Medical College, 1918; age 84; died August 17, 1978. He had practiced medicine in Ardmore for more than 60 years.

• **George A. Kyriazis,** Lansdowne; University of Athens School of Medicine, 1940; age 60; died August 25, 1978. He had been on the staffs of Delaware County Memorial Hospital, Haverford Hospital, and Presbyterian-University of Pennsylvania Medical Center and was clinical professor of obstetrics and gynecology at Hahnemann Medical College.

• **William A. Lustusky,** Mount Carmel; Georgetown University School of Medicine, 1929; age 73; died August 29, 1978. He had practiced general medicine in Mount Carmel since 1929.

• **Richard McLachlan,** Slippery Rock; University of Pittsburgh School of Medicine, 1951; age 62; died August 7, 1978. He had served as head of the student health department and as athletic team physician at Slippery Rock State College for 25 years. In 1976 he was presented the Layman Honor Award by the Pennsylvania State Association for Health, Physical Education, and Recreation.

• **John R. Mench,** Allentown; Jefferson Medical College, 1924; age 78; died September 2, 1978. He had practiced otolaryngology in Allentown for 50 years until his retirement in 1972.

• **Floyd Moser,** Andreas; University of Pennsylvania School of Medicine, 1944; age 73; died September 2, 1978. He had practiced radiology at Coaldale, Palmerton, Allentown, and Gnaden Huetten hospitals.

• **Mashel F. Pettler,** Beaver Falls; Hahnemann Medical College, 1919; age 82; died August 24, 1978. He had practiced medicine and dermatology in Beaver Falls and was a past president of the Beaver County Medical Society.

• **Ivo E. Rowland,** Joliet, Illinois; Medico-Chirurgical College of Philadelphia, 1913; age 90; died August 14, 1978. He had practiced otolaryngology in Charleroi and Elizabeth.

• **Theodore J. Saul,** Dushore; Georgetown University School of Medicine, 1934; age 68; died August 22, 1978. He had practiced medicine in Dushore since 1937 and had served as Sullivan County coroner for more than 20 years.

• **Isadore E. Smigelsky,** Mount Carmel; Jefferson Medical College, 1917; age 82; died September 12, 1978. He practiced medicine in Mount Carmel until his retirement in 1971 and had served as president of the Mount Carmel and Northumberland County medical societies.

• **David A. Snyder,** Philadelphia; Temple University School of Medicine, 1931; age 78; died June 26, 1978.

• **Norman L. Yood,** Media; Columbia University College of Physicians and Surgeons, 1939; age 64; died August 29, 1978. Dr. Yood held the rank of captain in the medical supply corps when he retired from the Navy in 1961. He was the former chief of radiology at the Philadelphia Naval Hospital.

• **Harry S. Ziemer,** Adamstown; University of Pennsylvania School of Medicine, 1920; age 85; died July 30, 1978. He had practiced family medicine in Adamstown for 55 years.

John P. Caffey, Highland Park; University of Michigan School of Medicine, 1919; age 83; died September 2, 1978. He was a prominent Pittsburgh radiologist who served on the staff of Children's Hospital, Oakland. He was a professor emeritus of radiology at Columbia University College of Physicians and Surgeons and was a visiting professor of radiology and pediatrics at the University of Pittsburgh School of Medicine.

E.E. Cliffton, Lansdale; Yale University School of Medicine, 1937; age 66; died June 11, 1978.

Clarence E. Dech, Bethlehem; Eclectic Medical College, Cincinnati, Ohio, 1938; age 88; died August 6, 1978.

Robert M. Hunter, Elkins Park; Hahnemann Medical College, 1921; age 80; died July 30, 1978.

Ross A. Kelly, Phoenix, Arizona; University of Pittsburgh School of Medicine, 1914; age 87; died February 28, 1978.

Harold A. Leffingwell, Lake Forest, Illinois; University of Pennsylvania School of Medicine; age 82; died August 12, 1978. He had practiced medicine in Sharon for several years.

Donna Kern McCurdy, Norristown; Tulane University School of Medicine, 1959; age 46; died July 28, 1978.

Clarence Mandelkern, Philadelphia; Temple University School of Medicine, 1936; age 69; died August 2, 1978. He had practiced medicine for more than 40 years.

John D. Milligan, West Newton; Bellevue Medical School, 1896; age 101; died June 8, 1978.

Francis K. Moll, Pottsville; Jefferson Medical College, 1928; died July 17, 1978.

Camilla R. Tuthill, Waymart; Johns Hopkins University School of Medicine; age 85; died August 5, 1978. She had been a pathologist at the Jersey City Medical Center, New Jersey, the Wilkes Barre General Hospital, and the Fox Memorial Hospital, Oneonta, New York.

When the somatic symptoms are there but the signs of organic disease are not

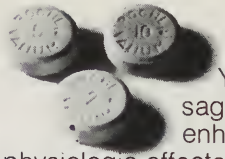
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for prompt, dependable relief of psychic tension and its somatic symptoms

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Valium works promptly and dependably to reduce excessive psychic tension. Often, your patient feels calmer within hours and within days response is both pronounced and sustained. Equally important, Valium is usually well tolerated. Side effects more serious than drowsiness, fatigue and ataxia are rare. Of course, as with all CNS-acting agents, patients on Valium should be cautioned against drinking alcohol or operating dangerous machinery. Periodic reassessment of therapy with Valium is also recommended.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).

The effectiveness of Valium (diazepam) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice, periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

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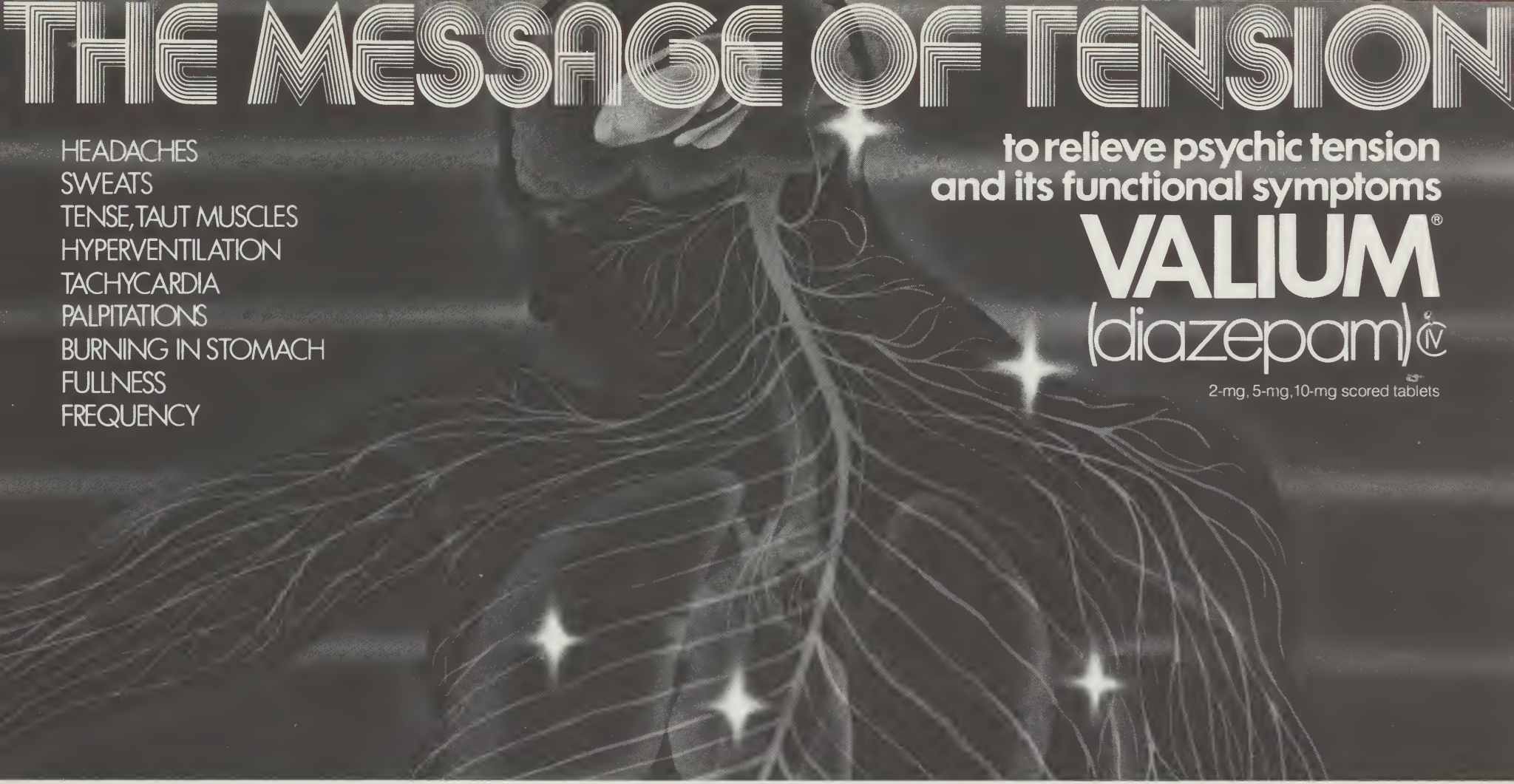
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Pennsylvania Medicine

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DPW CONCEDES

The Department of Public Welfare has withdrawn its ban on payments for benzodiazepines for patients on medical assistance in the face of the State Society's suit. The department announced that new regulations would be published in proposed form. Meanwhile, the Society has alerted the Commission on Therapeutics to be prepared to review the new proposal; physicians may continue to prescribe in the usual fashion; and the Society's suit, while not withdrawn, is at rest.

ACT 111 UPHELD

A ruling by the Supreme Court on November 1 that the arbitration system established by Act 111 is constitutional was a victory for PMS. The Court also ruled that findings of fact of the arbitration panels are admissable as evidence if a subsequent suit is filed in court. PMS entered the suit as amicus curiae and presented arguments supporting constitutionality.

ANNUAL SESSION HIGHLIGHTS

The PMS House of Delegates met in Lancaster October 30-November 1 to elect officers and set policy for the coming year. The House acted on 44 resolutions in addition to recommendations from officers, councils, and committees. Election results are on page six. Recommendations from the president and president elect are on page eight. Dues remain the same, $225 a year. Following are highlights of decisions made at the Annual Session.

Trustees terms shortened--The term of office for members of the Board of Trustees was shortened to three years from five years (Resolution 78-4). The two term limit is still in effect. The House referred to the Standing Committee on Constitution and Bylaws a recommendation that the limit be raised from two to three consecutive terms for members of the Board.

Membership rights expanded--The House restored full membership rights and privileges to Associate Members, effective immediately. This class of dues free membership may be chosen by those who have been members for 30 consecutive years and who have reached age 70. The House also approved a constitutional change establishing in the House a Resident Physician Section and a Medical School Section and giving a vote to each.

Chiropractic suit settlement approved--The House of Delegates approved the decision of the Board of Trustees to agree to settlement of the restraint of trade suit by the Pennsylvania Chiropractic Society against PMS and seven other defendants. Settlement terms include acceptance of the fact that "chiropractors are limited licensed practitioners in Pennsylvania" and "that physicians may or may not, at their discretion, accept patients sent by licensed limited practitioners." If the court accepts the terms of the agreement, the Society would not be admitting guilt, and would retain the right to question the scientific basis of chiropractic. In approving the Board's action, the House rejected a proposal in Resolution 78-17 which asked that the Board be overruled. The House reiterated its objection to the concept of chiropractic but said that PMS should conserve its resources for a chiropractic suit in Chicago which hinges on scientific merit.

Delegates authorize action on certified check policy--Arriving at Lancaster furious over "bureaucratic harassment" by the Bureau of Professional and Occupational Affairs in its surprise new policy of requiring certified checks or money orders in payment of license renewal fees, delegates voted a four step action plan (Resolution 78-33 and others). The plan was successful. On November 22 at a meeting with the governor's staff, it was revealed that there was no history of bad checks in the renewal of MD licenses, and the order was rescinded. Your personal check will be accepted--this particular bureaucratic harassment has been stopped.

Insurance company grows; seeks to cut surcharges, but increase premiums 7 percent--In its first annual report to the House of Delegates, the Pennsylvania Medical Society Liability Insurance Company (PMSLIC) revealed it has issued nearly six thousand policies and has a policyholders surplus of almost $9 million. David S. Masland, MD, PMSLIC president, announced at Annual Session that the company had submitted a rate filing which would reduce surcharges but increase base premium rates. Surcharges for corporations, associations, and partnerships would be reduced from 20 to 10 percent; vicarious liability surcharges for employed physicians would be reduced from 25 to 15 percent. The 7 percent base premium increase (effective January 1, 1979) is necessary to replace the surcharge revenue loss and meet the actuary's demand for additional premium. A week after the Annual Session, PMSLIC announced that A. John Smither, of Downingtown, has been named the insurance company's president, ending a six-month search to fill the post. Smither previously was senior vice president of Frank B. Hall & Company of Pennsylvania and administered the PMSLIC program there.

Foundation to continue IPA-HMO study--The Pennsylvania Medical Care Foundation will continue operations through 1979, with a directive from the House of Delegates that it establish an Independent Practice Association (IPA) Resource Center. With a budget of $102,000, the resource center will develop and support IPAs to maximize physician involvement in the operation of health maintenance organizations (HMOs) in Pennsylvania. The foundation will urge legislation permitting the operation of physician controlled HMOs in the Commonwealth and will seek federal funding to study the feasibility of organizing and operating physician majority HMOs. The foundation will continue its drug utilization and quality appraisal program and its liaison role with Professional Standards Review Organizations.

Constitution and Bylaws revision ordered--The House approved a recommendation calling for a revision, and a possible merging into one document, of the Society's Constitution and Bylaws (Resolution 78-1). The committee is to present a proposal to the 1979 Annual Meeting of the House. The House also lifted the two-year restriction in membership on the Committee on Constititution and Bylaws, in order to provide continuity and stability.

House expands Board position on smoking--The House approved the following statement, expanding the previously adopted policy by adding the underlined words: "(1) that the role of smoking as a public health hazard affecting both the smoker and the non-smoker be

recognized; (2) that the Society actively encourage and undertake appropriate patient education efforts designed to minimize health risks attributed to smoking; (3) that since physicians should be undisputed leaders in establishing personal health patterns which result in healthy living, we should encourage and assist our patients to stop smoking."

House sets new policy on fees--Responding to a recommendation from John B. Lovette, MD, the Society's new president, and Resolution 78-38, Reference Committee C recommended, and the House approved, this policy: "Members of the Pennsylvania Medical Society should voluntarily pledge themselves to lower the rate of increase in their fees so that changes in the physician fee component do not exceed any change of the Consumer Price Index on an annual basis." Delegates also endorsed the efforts of the Pennsylvania Voluntary Health Care Cost Containment Committee by approving Resolution 78-15. Also in the area of cost containment, Resolutions 78-12 and 13, dealing with reducing the number of hospital beds and planning for the use of beds, were approved.

PMS seeks longer response time on regulations--Delegates adopted Resolution 78-10, which directs that PMS join with other groups in seeking an amendment to the Commonwealth Document Law which would extend to at least 60 days the time given to react to proposed regulations.

Resolution 78-29 asks repeal of 'George Amendment'--Both student and medical school representatives spoke of the unfairness of the "George Amendment," a requirement in the appropriation bill each year that medical schools promise that 10 percent of each class will serve for four years in an area determined as medically needy by the Department of Health. The House voted to seek its retroactive repeal and to prevent its reintroduction, proposing instead the seeking of alternative methods of providing physicians for areas of need.

House supports physician involvement in risk management programs, limits PMSLIC coverage to PMS members--Acting on a recommendation in the presidential address of Dr. Lovette, the House directed the State Society to develop active leadership in the area of patient safety and risk management. Reference Committee E also recommended, and delegates concurred, that PMS membership continue to be required for all PMSLIC insureds.

Delegates oppose mandatory second opinion clause in health insurance policies--Two resolutions, 78-21 and 22, and a recommendation of the Board led to the adoption of a substitute resolution ordering an investigation into the proposed issuance of policies requiring a second opinion on elective surgery as a requirement for payment of health insurance benefits. The House also ordered that its objection be communicated to the AMA House of Delegates, the state insurance commissioner, and the Prudential Insurance Co., which is said to have such a policy.

House orders AMA membership campaign--Acting on a recommendation of Dr. Lovette, the house vote implementation of a special campaign to increase AMA membership in Pennsylvania, to reverse the decline which has occurred in recent years. The House also supported Resolution 78-16, which calls for identification of AMA members by ribbon or emblem at meetings of the PMS House of Delegates.

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Pennsylvania Medicine

December 1978 Volume 81, Number 12

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Society's new officers begin terms; board reorganizes

Leroy A. Gehris, MD, Reading family physician, was elected vice president of the Pennsylvania Medical Society during the 1978 meeting of the House of Delegates October 30, in Lancaster. Matthew Marshall, Jr., MD, Pittsburgh urologist, moved up from vice president to president elect as John B. Lovette, MD, Johnstown surgeon, was installed as president.

A graduate of Jefferson Medical College, Dr. Gehris completed his internship and residency training at Germantown Hospital, Philadelphia, and served 40 months in the U.S. Army in Vancouver, Washington and the European Theatre of Operations.

He has been active in organized medicine since 1939. He was president of the Berks County Medical Society in 1958 and a member of the society's executive council for 19 years, serving as chairman in 1968. He served as a county society delegate to the PMS House of Delegates for 15 years.

Dr. Gehris served the State Society in a number of capacities, including membership on the Council on Public Service for six years. In 1969 he was elected trustee from the Second Councilor District, and has served as the chairman of the Finance Committee since 1975.



Dr. Keck



Drs. Andriole, Fetterman, and Davis

Trustees, other officers

Delegates also elected four trustees. J. Mostyn Davis, MD, Shamokin, succeeds George A. Rowland, MD, Millville; and Ralph S. Blasiole, MD, Washington, succeeds William C. Ryan, MD, Somerset. Henry H. Fetterman, MD, Allentown, was elected to fill the unexpired term of Dr. Gehris. Raymond C. Grandon, MD, New Cumberland, was reelected trustee.

D. Ernest Witt, MD of Bloomsburg, was reelected speaker of the House and Donald E. Harrop, MD, of Phoenixville, was reelected vice speaker. G. Winfield Yarnall, MD, Harrisburg, was reelected secretary.

Elected to the Society's Judicial Council were: Orlo G. McCoy, MD, Canton; George E. Farrar, Jr., MD, New Hope; and Cyrus B. Slease, MD, Kittanning.

Delegates also elected six delegates to the American Medical Association House of Delegates for two year terms. They are: R. William Alexander, MD, Reading; James B. Donaldson, MD, Philadelphia; Raymond C. Grandon, MD, New Cumberland; William J. Kelly, MD, Pittsburgh; Michael P. Levis, MD, Pittsburgh; and William Y. Rial, MD, Swarthmore.

Six alternate delegates were elected. They are: Donald C. Brown, MD, Irwin; Betty L. Cottle, MD, Hollidaysburg; Joseph N.



Drs. Gehris and Grandon

Demko, MD, Scranton; Charles A. Heisterkamp, III, MD, Lancaster; John L. Kelly, MD, Media; and Irving Williams, MD, Lewisburg.

Board reorganizes

The Society's Board of Trustees in a reorganization meeting immediately following the adjournment of the House of Delegates elected David J. Keck, MD, Erie, chairman and Raymond C. Grandon, MD as vice chairman.

The Board reelected as treasurer John F. Rineman, the Society's executive vice president. David A. Smith, MD, of Harrisburg, was reelected medical editor of PENNSYLVANIA MEDICINE; and Pepper, Hamilton & Scheetz was renamed legal counsel.

Censors named

Delegates also elected the following physicians as district censors. They include: **Adams** (county): W. North Sterrett, Ardentsville; **Allegheny:** William D. Stewart, Allison Park; **Armstrong:** Donald W. Minteer, Worthington; **Beaver:** John G. Hallisey, Aliquippa;

Berks: Brian A. Wummer, Womelsdorf; **Blair:** John W. Stoker, Altoona; **Bradford:** Arthur B. King, Sayre; **Bucks:** Stanley F. Peters, Plumsteadville; **Butler:** Robert C. McCrory, Butler; **Cambria:** Warren F. White, Johnstown;

Centre: H. Thompson Dale, State College; **Chester:** John B. Coates, Jr., Phoenixville; **Clarion:** Charles C. Huston, Knox; **Clearfield:** Fred Pease, Clearfield; **Clinton:** George J. Treires, Lock Haven; **Columbia:** C. Perry Cleaver, Catawissa;

Crawford: David D. Kirkpatrick, Jr., Meadville; **Cumberland:** Hans S. Roe, Carlisle; **Dauphin:** Robert P. Dutlinger, Middletown; **Delaware:** Furman T. Kepler, Havertown; **Erie:** Robert L. Loeb, Erie; **Fayette:** Veronica Binns, Brownsville;

Franklin: Albert W. Freeman, Shippensburg; **Greene:** Arthur J. Patterson, Waynesburg; **Jefferson:** Nicholas F. Lorenzo, Brockway; **Lackawanna:** Tomas A. O'Boyle, Moscow; **Lancaster:** William G. Ridgway, Akron; **Lawrence:** John M. Corbett, New Castle;

Lebanon: John Walmer, Lebanon; **Lehigh:** William F. Boucher, Northampton; **Luzerne:** Joseph W. Ehrhart, Forty-Fort; **Lycoming:** Franklin G. Wade, Williamsport; **McKean:** Bruno P. Sicher, Kane; **Mifflin-Juniata:** Donald E. Basom, Lewistown;

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Philadelphia: Brooke Roberts, Philadelphia; **Potter:** Francisco B. Villa, Coudersport; **Somerset:** Alexander Solosko, Meyersdale; **Susquehanna:** Paul B. Kerr, Montrose; **Tioga:** William P. Reich, Wellsboro; **Union:** Joseph Weightman, Lewisburg;

Venango: Harry Kanhofer, Titusville; **Warren:** Harold J. Reinhard, Warren; **Washington:** William H. Kittrell, McMurray; **Westmoreland:** Leslie S. Pierce, Greensburg; **Wyoming:** John S. Rinehimer, Jr., Tunkhannock; and **York:** Donald R. Gross, York.

Hospitals urged to stock vaccine

Effective Jan. 1, 1979, the Pennsylvania Department of Health will no longer stock biologics for patients requiring treatment following animal bites, according to Robert E. Wallace, deputy secretary for public health programs.

The Department of Health is recommending that all local hospitals stock human rabies immune globulin, Hyperab (Cutter Laboratories), in pediatric and adult dose vials, with at least starter supplies of rabies vaccine.

Wallace explained that budgetary limitations prohibit the department from stocking supplies of duck embryo vaccine, DEV (Lilly), in addition to Hyperab.

"Our most recent practice of keeping small quantities in district offices only has resulted in serious logistic problems," Wallace said. The new system will "serve the best medical interests of the patients," Wallace stated.

Consultative services will continue to be available from the department's Division of Epidemiology. In addition, the department will help in securing the still-experimental human diploid cell strain rabies vaccine, WRV, now available from the Center for Disease Control for selected cases. Call (717) 787-5460 for such services.

Top officers set tone of annual delegates' meeting



Dr. Lovette



Dr. Blady

John B. Lovette, MD the 129th president of the Pennsylvania Medical Society, punctuated his address to the House of Delegates October 30 with seven recommendations. He urged delegates to use the relative calm of the 1978 meeting to prepare for tomorrow's challenges.

To preserve the private practice of medicine, he told delegates, "We must take strong voluntary action on fees. **Members of the Pennsylvania Medical Society should pledge themselves to lower the rate of increase in their fees so that it does not exceed the overall Consumer Price Index on an annual basis."**

With government rapidly becoming the largest purchaser of health care, he cautioned that it must not be permitted to attain monopoly status. The day the private practitioner is snuffed out is the day that we bury quality medicine in America," Dr. Lovette said.

He urged private health insurers to innovate in order to reduce costs and forestall a government takeover. Dr. Lovette said, **"I recommend that PMS study the feasibility of changes in health insurance policies to build in some incentives (through co-payment, deductibles, surcharges, discounts, etc.) to involve the insured more in the cost of utilizing the plan.**

"Ultimately, if patients continue to have some stake in the financing of their care and have available options as to where and when and how it will be purchased, our patients will be far more effective in regulating the marketplace than some bureaucrat picking cherry blossoms beside the Potomac," he said.

A recommendation that the Society join the private insurance industry in developing experiments in risk sharing which include both hospitals and private physicians was accepted by the reference committee but rejected by the House.

In the area of malpractice risk management, Dr. Lovette, who is also a member of the board of the society's liability insurance company (PMSLIC), said, "I recommend that PMS develop active leadership in patient safety and risk management. If we do not seize this opportunity, the hospital will fill the vacuum."

He cited the importance of American specialty societies and their entry into areas of economics and legislation. He said, "This advocacy in areas of economics and legislation carries with it the potential for division."

Calling on delegates from the specialties and county societies to develop a "sense of family", Dr. Lovette made two recommendations designed to strengthen the unity of the profession:

"I recommend that those specialty societies which presently do not purchase administrative services from the PMS Department of Specialty Society Services offer PMS the opportunity in the next year to make a sales presentation to them and that each society give

Nuclear medicine officers elected

Michael B. Dooley, MD, chief radiologist at Phoenixville Hospital, Phoenixville, was elected president of the Pennsylvania College of Nuclear Medicine at its annual meeting in October.

Dr. Dooley is a past president of the Chester County Medical Society and the Phoenixville Hospital medical staff. He is currently serving as clinical assistant professor of radiology at Temple University School of Medicine.

Donald Morel, MD, Orefield, was elected vice president. Robert L. Bell, MD, Chester, was elected historian. Board members-at-large are: Everett F. Oesterly, Jr., MD, Allegheny; Joseph S. Burkle, MD, York; John R. Hansell, MD, Philadelphia; and Walter Wartonick, MD, Mountaintop.

The Pennsylvania College of Nuclear Medicine now has approximately 110 members consisting of radiologists, pathologists, internists, and other physicians interested in nuclear medicine.

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Drs. Lovette, Blady express health care cost concerns

serious consideration to securing administrative services from PMS."

Secondly, he recommended that "a special study be made of certain common services which might be provided by PMS for all specialty societies in Pennsylvania, particularly as they relate to the new PMS computer."

The Johnstown surgeon concluded his address by asking the Society to engage in "a special year long campaign to increase AMA membership in Pennsylvania to reverse the decline which has set in over the past several years."

Earlier delegates heard outgoing president John V. Blady, MD, of Philadelphia, report on highlights of the year.

Dr. Blady noted that in approximately 90 days the Society had raised nearly $8.7 million in policyholder surplus to launch the Pennsylvania Medical Society Liability Insurance Company. Today the company serves nearly 5,300 physicians, making it the second largest phvsician insurer in the Commonwealth.

Dr. Blady said substantial savings accrued to members when the Society successfully opposed the Catastrophe Loss Fund Ten Percent surcharge and achieved a 48 percent cut in the workmen's compensation rate for physicians' offices.

Dr. Blady reported progress in the Society's suit against the State Board of Medical Education and Licensure. Since the suit the medical board has hired more employes, including attorneys, hearing examiners, and medical investigators.

He also reported progress in the Society's suit against the Department of Public Welfare for its attempt to ban payment for most benzodiazepines.

Dr. Blady told delegates that the Society is pursuing legal action in twelve different cases ranging from countersuit to tests of constitutionality before the Pennsylvania Supreme Court.

Noting the Society's involvement in the voluntary cost containment program of the AMA and the American Hospital Association, Dr. Blady said: **"My own belief is that cost containment, medical economics, and political education must become part of the medical school curriculum. We must educate our graduating colleagues not only in how to practice quality health care but also how to survive in the arena of the political medical marketplace."**

Dr. Blady concluded his report to the House by saying, ". . . PMS works! We're fighting for doctors! We're winning some important battles! We are challenging government bureaucrats! We are negotiating with the legislators! We are meeting with the candidates! We are acting rather than reacting, *and* we are listening to members!

My message to those who critize is—get involved. Experience firsthand some of the frustration but also the satisfaction in dealing with today's problems."

Orthopaedic Society presents first award

The Pennsylvania Orthopaedic Society has presented its first annual award for a scientific paper to Eric I. Mitchell, MD, of the University of Pennsylvania Department of Orthopaedic Surgery, for his paper, "Recognition and Treatment of Blout's Disease with Osteoclasis." The award was presented at the society's annual scientific meeting in Southampton, Bermuda. The meeting was held in conjunction with the New Jersey Orthopaedic Society.

Officers for 1979 were elected at the meeting. They are: president, Marvin E. Steinberg, MD; vice president, William A. Steinbach, MD; secretary-treasurer, Francis A. Lovecchio, MD; program chairman, Henry H. Sherk, MD; membership chairman, Peter A. Kablish, MD.

Executive Committee members are: Thomas K. Howard, MD; James H. McMaster, MD; Jerome M. Cotler, MD; and William T. Green, Jr., MD. AAOS Councilors are: John A. Perri, MD; Martin L. Beller, MD; and Robert N. Richards, MD. PMS Delegates are: Robert B. Greer, MD; and Paul A. Lotke, MD (alternate).

Thoracic surgeons meet

Cardiothoracic surgeons from Pennsylvania and neighboring states gathered for the 16th annual meeting of the Pennsylvania Association for Thoracic Surgery in Hershey. Participants conducted a scientific program which attracted nurses and paramedical personnel from the Hershey Medical Center.

John Y. Templeton, III, MD, Philadelphia, delivered the dinner address.

John A. Waldhausen, MD, professor of surgery and chairman of the department of surgery at the Hershey Medical School presided. New officers elected for 1978-79 are: James L. Harrison, MD, Williamsport, president; Dr. Templeton, vice president; Joseph C. Donnelly, Jr., MD, secretary; and Horace MacVaugh III, MD, treasurer, all of Philadelphia.

Tax deductible donations to provide loans to medical students may be made now for 1978 income tax purposes. Send your check to the Educational and Scientific Trust, 20 Erford Road, Lemoyne, PA 17043.

MDs in the news

Thomas V. Sedlacek, MD, Philadelphia, has been named professor and chairman of obstetrics and gynecology at Hahnemann Medical College and Hospital. He has been acting chairman since 1977 and director of gynecologic oncology since 1976.



DR. SEDLACEK



DR. ETZEL

Conrad A. Etzel, MD has been elected president of the medical and dental staff of the Crozer-Chester Medical Center. Dr. Etzel specializes in obstetrics and gynecology. He succeeds **L. Luke Cellini, MD.** Also elected were **John J. Laskas, Sr., MD,** vice president and **Paul Cass, MD,** secretary/treasurer.

Robert A. Clark, MD, has retired from the medical staff of Friends Hospital, Philadelphia, after 23 years of service. Dr. Clark, a clinical professor of psychiatry at Hahnemann, was instrumental in bringing outpatient services to Northeast residents and served as the first director of the Northeast Mental Health Clinic.

Robert F. Dickey, MD, Danville, recently was honored by Geisinger Medical Center with the renaming of the East Clinic to the Dickey Clinic. Dr. Dickey is former assistant executive director at Geisinger, a retired director of the department of dermatology, and a former president of the Institute for Medical Education and Research.

Two Wyoming County physicians recently were honored by their county medical society for 50 years of medical service. **William J. Llewellyn, MD,** began his practice in Wilkes-Barre in 1928 and in 1933 moved to Nicholson, where he has been practicing ever since. **P. J. Morgan, MD,** was appointed to the surgical staff at Wilkes-Barre General Hospital in 1928 and he has continued to practice in that community.

William F. Bouzarth, MD, Philadelphia, recently was elected vice president of the American Association for the Surgery of Trauma. Dr. Bouzarth is clinical professor of neurosurgery at the Medical College of Pennsylvania.

Delphine Bartosik, MD has been named acting director of the division of gynecologic endocrinology, department of obstetrics and gynecology at the Hahnemann Medical College and Hospital. Dr. Bartosik completed her residency in obstetrics and gynecology at the University of Pennsylvania Hospital. She had been associate professor of obstetrics and gynecology at the New York Medical College.

Cyril H. Wecht, MD, Allegheny County coroner, was presented with the Speaker of the Year Award by the Speech Communication Association of Pennsylvania at their 39th annual convention.

Kirkley R. Williams, MD, Wayne, has been named director of the department of surgery at Bryn Mawr Hospital. He has been a member of the medical staff at the hospital since 1964 and has published numerous papers on cardiovascular surgery.



DR. WILLIAMS



DR. DONALDSON

Milton H. Donaldson, MD was elected president of the Philadelphia division of the American Cancer Society. Dr. Donaldson succeeds **Luther W. Brady, MD** who completed two years as volunteer head of the nonprofit agency. Dr. Donaldson is vice president for cancer control, training, and education at the Fox Chase Cancer Center. He has served as a volunteer for the society for over eight years. **C. Jules Rominger, MD,** Rosemont was elected as medical vice president.

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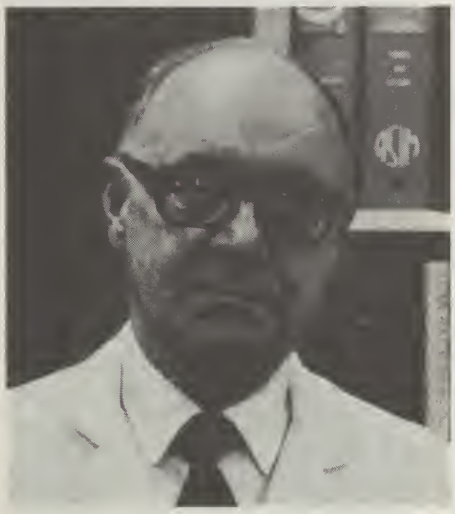
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—Dr. William Felts, Past President, American Society of Internal Medicine



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What else are physicians doing? Minimizing their patients' hospital stays, whenever possible. Reevaluating routine admissions procedures. Questioning the real need of the diagnostic tests they order for their patients. Avoiding duplicate testing. Trying to discourage their patients' demands for unnecessary medication, treatment or hospitalization. Compiling daily logs of their medical decisions and what they cost. And more.

More physicians today realize what a tough problem we're all faced with. They know this is a challenge for medicine. And that physicians are in the best position to deal with and solve the problem.

**PATIENT CARE Magazine—Outlook 1977, "Face-Off: Cost Containment vs. Chaos," January 1, 1977.*

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Office counseling

Emotional problems of physicians and their families

Joyce D. Kales, MD
Enos D. Martin, MD
Constantin R. Soldatos, MD

Practicing medicine provides many rewards, yet at the same time it is highly demanding and stressful. The physician receives both internal and external gratification from his role as a practitioner. Inwardly, he develops a strong sense of self-esteem and accomplishment because he is significantly responding to the needs of his fellow human beings. Outwardly, like the clergyman, the physician is placed in a privileged position in the community. Along with these gratifications, however, there are extremely high expectations from both the public and himself for continued excellence in all areas of his life and practice. The pressure of these expectations may lead to feelings of insecurity. At times the need to be successful and maximally competent may overwhelm the physician.

As a group physicians are highly susceptible to emotional problems, drug abuse, unstable marriages and suicide. Studies also suggest that the spouses and children of physicians have a higher incidence of emotional distress. This paper discusses the types of students selected by medical schools, and environmental stresses commonly experienced by physicians. The paper also describes the personality characteristics common to physicians which may predispose them to developing psychiatric difficulty. Marital patterns as well as the development of emotional disturbance in the physician's spouse are considered, followed by a discussion of the effects of the physician's life-style on his children. Finally, we offer recommendations for dealing with stress and for strengthening healthy coping mechanisms.

Selection of physicians

The medical school selection process favors students who do well in examinations, who are interested in the physical sciences and who are generally conventional and prone to emotional restraint. Admissions committees usually look for the capable, well rounded applicant. During the interview process, the student applicant usually expresses humanitarian interests. He attempts to present himself as the type of person the school reputedly recruits.

Currently no selection procedures exclude students who are apt to develop emotional difficulties. Two exceptions are when it is obvious during an interview that an applicant is disturbed or when recommendations indicate negative personality traits or behaviors.

Competitive selection processes guarantee an elite group of accepted applicants. Generally they are academically qualified, well motivated students with records of outstanding achievement and performance. Thus, a student rarely fails in medical school due to intellectual deficits. But, information overload, or feelings of isolation or self doubt may disrupt his concentration and the learning process and trigger emotional problems manifested by learning difficulty.

Medical students who receive help for emotional problems generally respond to treatment and maintain their potential to be good doctors. Where a student mental health service is available, an estimated 40 to 60 percent of all medical students are seen once or more during their four years of training. The student who cannot or will not recognize his serious emotional problems will probably experience difficulty in the future.

Dr. Kales is director of the division of community psychiatry of the department of psychiatry at The Pennsylvania State University College of Medicine, Hershey. Dr. Martin is assistant director of the division of inpatient psychiatry and Dr. Soldatos is assistant professor in the department of psychiatry. This is the eleventh in a series of articles on office counseling for primary care physicians, a project of the departments of psychiatry of the state's medical schools and the Pennsylvania Psychiatric Society.

Environmental stresses

Workload—Medical practice imposes considerable strains. Few professions demand as much time; the average physician works from 60 to 80 hours per week. Professional meetings and continuing education requirements further erode leisure time. Even when off call, the physician's mental preoccupation and chronic anxiety over practice responsibilities may impair his ability to relax, unwind, and devote adequate attention to family activities and concerns.

Research indicates that practicing medicine also involves excessive psychophysiologic stress. A recent study of surgeons revealed that the mean heart rate while performing operations was 121 beats per minute, with maximum rates in some cases of over 150 beats per minute. The physical labor needed to produce this heart rate normally could not be sustained for more than 10 or 15 minutes.

The woman physician must cope with the additional responsibilities of managing a home, caring for children and assuming the societal role assigned to a wife. She is expected to be a "super woman" as well as a competent physician.

Threat of malpractice—In the past the glamour of being a doctor, so familiarly portrayed in television and movies, at least partially compensated for the excessive stress produced by the physician's heavy workload. Recently however, along with the rise in medical specialization and improved technology, the profession has lost considerable popular respect.

The public has developed unlimited expectations for care. Frustrated with rising costs and the impersonal aspects of medical and laboratory procedures, patients have become more critical and more likely to bring suit for malpractice. This, of course, adds greatly to the stresses placed on the physician.

Doctor-patient relationship—Every encounter between physician and pa-

tient has the potential to arouse deeply rooted emotions in both parties. In some ways these feelings are experienced as repetition of the close, parent-child relationship. They may have a therapeutic effect and often they can contribute to successful treatment by facilitating the patient's adherence to the doctor's recommendations. These same feelings may also create problems especially where complications develop, treatment is unsuccessful, or patients become overly dependent. In these cases, both patient and doctor feel frustrated and alienated.

Establishing appropriate rapport with a patient is a demanding task: the physician must express interest and support, but must avoid becoming too involved or personal. An example of potential difficulty is evident in managing the seductive, attractive patient who uses her sexuality as an invitation for a closer relationship. The male physician can neither respond in kind nor be cold and rejecting. He must fulfill the patient's need for attention without infantilizing or taking advantage of her. Another difficult encounter occurs with the hostile, critical patient who is provocative and challenging toward the physician. Again, the physician cannot respond in kind, but should recognize the frightened person beneath the patient's aggressive facade.

Personality characteristics

Family background—Compared with matched controls, physicians were more over-protected as children. Normal separation from parents was delayed or failed to occur. In early life, many physicians worked hard and delayed or denied themselves gratification in an effort to please a critical parent who was never quite satisfied.

Excellent clinicians can come from troubled family backgrounds; however, those physicians having more psychiatric difficulty were found to have had less stable childhood environments.[2] Problems tended to arise when the physician who was emotionally deprived as a child became overburdened by the demands of his troubled patients.

Personality traits—Physicians tend to be perfectionistic and demanding of themselves. In stressful situations, the physician may respond with self doubt, pessimism and feelings of inferiority. Fears of failure, or an event which is perceived as an actual failure, can generate exaggerated or unwarranted anxiety, shame or guilt.

The physician strives for intellectual mastery. Since he may be uncomfortable with emotion, he has a tendency to separate feelings from thoughts, and may appear mechanical in dealing with his patients. He exhibits a need to be in control and avoids dependency, passivity and weakness in himself.

The physician's personality traits coupled with the daily demands of his practice result in "role strain."[3] He allows himself no regression and continually drives himself without "recharging his batteries." Under stress, the physician falls back on what he does best: work. Work becomes an escape from anxiety and is frequently self-imposed.

Physicians who are under stress may develop hypochondriasis; through this symptom, anxiety is channeled into physical complaints. The physician's typical personality discourages him from experiencing the patient's role, which he associates with feelings of helplessness and dependency, and loss of control, autonomy, and physical and psychological privacy. The physician also resists psychiatric treatment by declaring that emotional problems are a weakness and denying such problems in himself. Physicians are unwilling to seek help to an almost phobic degree. They are most reluctant to inconvenience their medical colleagues.

When the physician's defenses break down, the problems that surface most frequently are depression, alcohol or drug abuse, and marital problems. Symptoms of these problems are: irregular and inefficient work hours, disturbed sleeping and eating habits, withdrawal from the family, difficulty in managing patients, and reluctance to make referrals. Relatively high rates of alcoholism, a high prevalence of addiction to narcotics, and an incidence of suicide that is two to three times higher than that of the general population have been reported for physicians. The most prominent problem, however, appears to be a high rate of bad marriages: 45 to 70 percent of physicians' marriages suffer from serious problems.

The physician's spouse

Marital patterns—Many doctors select spouses who will fulfill their deep-seated needs to be taken care of. Thus, the male physician is likely to turn to his wife for mothering, and in exchange may provide handsomely for her material needs or even her unwarranted demands.

Extended absences from home, particularly on special family occasions, may alienate the physician from his wife and children. Even when he is present he may be preoccupied and unresponsive to emotional appeals from his family. The physician's wife may come to expect only material goods and entertainment from him in place of authentic affection, attention and concern.

The wife may be further affected by her inability to share her husband's professional activities and achievements. There is a sense of disappointment and feeling left behind while her husband "goes up the ladder." Resentment rather than pride may be her reaction and communication between the partners is impaired further. This is most probable when the wife has considerable potential herself but feels she must put her husband's needs and ambitions before her own. If the wife decides to end the marriage, the blow to the physician's self-esteem may be unbearable, especially when the wife develops another relationship that is purely emotional and non-material.

Emotional illness in wives—The physician who experienced an emotionally deprived childhood may choose a spouse with a similar background. He is initially attracted by her dependency on him and also hopes to provide her with the care that he was denied as a child. The wife may have unlimited emotional needs, however, and the physician-husband cannot continuously devote the required time and attention.

When the wife's needs are not fulfilled, she may begin to exhibit unpredictable and disturbed behavior. This places an additional strain on the physician. The situation is further complicated when the physician ignores his wife's need for psychiatric help and tries desperately to restore her psychologically by himself. He may overlook severe depressive symptoms in his wife that may eventually lead to suicide attempts. He also may tolerate or even unintentionally promote his wife's escape to alcohol and/or drug abuse. The latter often develops with his direct involvement since he can supply the medications for his wife's ill-defined somatic complaints.[4]

As the marital situation worsens, the physician may become more detached and his wife more desperate for his attention. In cases where the wife is referred for psychotherapy, conjoint marital therapy often is not instituted, thus perpetuating the physician husband's lack of involvement and the labeling of the wife as "sick."

Children of physicians

A similar pattern of neglect can develop with the physician's children. Material goods may replace appropriate limit setting and spending time together. In addition, the physician may subject his children to the same high expectations and performance standards that he sets for himself, neglecting to provide them with the necessary emotional support.

In some cases, the physician will give undivided attention to his children only when they become physically ill or emotionally disturbed. Treatment of physical and emotional problems may be inadequate and fragmented because of the physician's reluctance to obtain a thorough evaluation for the problem. When the emotionally disturbed child is referred for psychotherapy, it may be difficult or impossible to involve the physician parent in family therapy. When the physician parent assumes only the role of provider for his children, he may develop feelings of loss and estrangement as they grow and become financially independent.

On the other hand, the physician parent provides his children with an excellent example of commitment to helping others and a life of study and continuing education. Thus, it is not surprising that physicians' children may become physicians themselves or develop other productive professional careers. Even the negative effects that the physician's professional life may have upon his family can be compensated for if the child receives support, help and attention from both parents during critical periods.

Recommendations

Preventing future emotional difficulties should begin on the medical school level. The student selection process commonly favors or even reinforces such qualities as intellectualization and emotional detachment and inhibition. These characteristics should not be over emphasized. Outgoing, down-to-earth individuals who are sensitive yet not vulnerable to other people's suffering are more preferable. Patience, consistency, and persistence in the pursuit of goals are desirable attributes and should not be confused with rigidity and inflexibility.

Psychiatric counseling should be provided to medical students, their wives and other family members. Early intervention and management of emotional difficulties can prevent the development of serious psychiatric problems.

Practicing physicians should understand the nature and extent of their professional psychological hazards. Seminars that include spouses and focus on these problems may be helpful. Physicians should be urged to recognize and gratify their own emotional needs and those of their families.

Physicians should avoid total preoccupation with their practice, especially when they are home. They should *willingly* allocate time to their families' activities and interests. If, however, this is done mechanically with little attention or sensitivity it may be more harmful than absence or no involvement. Physician fathers need to attach the necessary priority to everyday family life activities. Some physicians' tendency to respond only to family crises or serious problems can lead to family members "competing" with the medical practice, thus leading to more problems.

Physicians should become flexible in sharing domestic tasks and parenting with their spouses. Rigid role definitions such as, "I run the office, she runs the home" should be avoided since alienation and deprivation of mutual support may result.

Early diagnosis and treatment of the psychiatrically impaired colleague is crucial. The issue of drug or alcohol abuse should be dealt with directly and firmly. Untimely, early discharge of the physician from a treatment program at his insistence may cause irreparable damage and should be avoided. Whenever marital or family therapy is needed, the physician parent should be involved. All possible problems should be explored, such as sexual difficulties or substance abuse. There should not be any taboos when a physician treats the psychiatric problems of a colleague. As with any other patient, failure to deal appropriately with the physician patient will eventually lead to more difficulties.

The physician's wife needs to be encouraged to develop her own personal identify. Often she has unfulfilled aspirations which she ignored to obtain her role as a doctor's wife.

Summary

Almost every physician experiences the strains of his profession. If preventive measures and therapeutic interventions are appropriately undertaken whenever indicated, the psychological problems of physicians and their families can be reduced significantly.

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Mediastinoscopy: a diagnostic and prognostic operation

John L. Pennock, MD
W. Minster Kunkel, MD

Surgical treatment for bronchogenic carcinoma is based on selectivity which prevents unwarranted thoracotomies and their accompanying operative risks.

Daniels in 1949 reported on the biopsy of scalene lymph nodes with a diagnosis of intrathoracic disease.[1] In 1954 Harken developed the natural progression from scalene node biopsy.[2] His technique exposed the anterior scalene muscle via a standard paraclavicular incision but extended the procedure by entering the lateral mediastinum using a laryngoscope. The technique of anterior cervical mediastinoscopy was developed and recorded by Carlens in 1959.[3]

The current study consists of 100 mediastinoscopic procedures performed at the Harrisburg Hospital from 1971 to 1976. Eighty patients had malignant disease and twenty patients had benign disease.

Technique

Preliminary bronchoscopy was performed on all patients. Mediastinoscopy is performed under general anesthesia with endotracheal intubation. A 4- to 5-cm transverse incision is made 2 cm above the sternal notch. The strap muscles are spread longitudinally and the pretracheal fascia is incised vertically.

The surgeon passes his index finger along the anterior surface of the trachea deep to the pretracheal fascia. If a proper plane has been entered, little resisitance will be encountered as the finger passes into the mediastinum to the level of the carina.

The areolar tissue of the mediastinum is dissected free of the anterior and lateral walls of the trachea with a rolling or sweeping motion of the index finger. Paratracheal nodes are palpable if enlarged by inflammation or neoplasm; normal lymph nodes are not palpable. The aortic arch and the innominate artery are anterior to the surgeon's finger.

A Carlen's mediastinoscope is inserted into the track left by the finger.

TABLE 1
Diagnosis in Patients with Benign Disease Following Mediastinoscopy

17 Positive Node Biopsies - 85%

Disease	No. of cases
Sarcoidosis	13
TB, granuloma	4
Pulmonary fibrosis	1
Benign cyst	1
Pneumonia	1

TABLE 2
Results of Mediastinoscopy Performed
Results of Mediastinoscopy Performed on Patients with Malignant Disease

Operable Cases - 20 patients (25%)
18 negative node biopsies (90%)
2 positive ipsilateral bronchial node biopsies (10%)

Inoperable Cases - 60 patients (75%)
46 positive node biopsies (59%)
7 positive node biopsies + other
7 negative node biopsies + other

The dissection is extended with a closed end suction tip under direct vision for several centimeters along the anterior surface of each mainstem bronchus.

Both pulmonary arteries, the azygous vein, and the left bronchial artery can be dissected and visualized. Hilar, subcarinal, and paratracheal lymph nodes can be removed or biopsied. Prior to biopsy the lymph node or lesion is always aspirated with a needle and syringe.

Results

Anterior cervical mediastinoscopy was performed on 100 consecutive unselected patients between 1971 and 1976. One hundred and sixty-two node biopsies were obtained. A positive biopsy rate of 45 percent (73/162) was obtained. The mortality rate for this series of patients was 0 percent, and the morbidity rate was 1 percent. One patient experienced excessive bleeding before node biopsies could be obtained. The bleeding was controlled and the procedure was terminated without biopsy.

Diagnosis was made in 17 of 20 (85 percent) patients with benign lesions. The highest incidence of positive diagnosis in patients with benign lesions was in sarcoidosis and granulomas (Table 1).

Mediastinoscopy was performed on 80 patients with primary carcinoma of the lung. Forty-six patients were considered inoperable by positive mediastinoscopy alone. Twenty patients, of whom 18 had negative mediastinoscopic biopsies and 2 had ipsilateral

bronchial biopsies, were considered operable by mediastinoscopy. Two patients were found to have superior mediastinal spread identified at the time of thoracotomy (Table 2). The resectability rate in this series of patients is 90 percent (Table 3). Table 4 shows the relation of cell type to findings at mediastinoscopy.

Five of fourteen cases of squamous cell carcinoma were free of disease two to five years post-surgery (35.7 percent). One of three cases of adenocarcinoma of the lung remained free of disease four years post-surgery. No case of small cell carcinoma or undifferentiated carcinoma of the lung survived more than 15 months (Table 5).

False negative mediastinoscopy with superior mediastinal spread identified at the time of resection and thoracotomy occurred in two patients (11 percent). The majority of these metastases were in locations which are not accessible at mediastinoscopy.

TABLE 3
Status of Operable Cases Following Thoracotomy

Results	No. of cases
Mediastinal spread	2
Death (5% operative mortality rate)	1
Deaths due to disease	3
Unresectable (90% resectability rate)	2
Metastatic disease with follow-up	8
Disease free	6
7.5% of patients with cancer	
30.0% of operable cases	

TABLE 4
Relation of Cell Type to Findings at Mediastinoscopy

Cell type (percent)		Positive mediastinoscopy (percent)
Squamous cell	- 56	57
Small cell	- 12	89
Adenocarcinoma	- 12	66
Undifferentiated	- 20	80

TABLE 5
Survival Rate of Operable Cases by Cell Type

Cell type		Survival rate
Squamous Cell	- 14	5 (35.7%)
Small Cell	- 0	0
Adenocarcinoma	- 3	1
Undifferentiated	- 3	0

Discussion

Mediastinoscopy permits biopsy of the lymph nodes in the upper mediastinum. Employing this procedure aids in establishing the diagnosis of intrathoracic diseases. Mediastinoscopy establishes diagnosis of intrathoracic sarcoidosis in approximately 90 percent of patients with the disease. Scalene fat pad biopsy provides a diagnosis in less than 80 percent of patients with Boeck's sarcoid and is an excellent diagnostic procedure when this condition is suspected.

A positive tissue diagnosis in patients with carcinoma of the lung is reported in less than 25 percent of scalene fat pad biopsy. Superior mediastinal spread in 59 percent of cases of carcinoma in this series was considered evidence of non-resectability. Unrewarding thoracotomy was avoided.

The positive mediastinal biopsy rate in this series of patients with lung cancer is high compared to other series reported in the literature.[4-6] However, 20 percent of our patients had undifferentiated carcinoma and 12 percent had oat cell carcinoma of the lung, cell types with a high positive mediastinal biopsy rate in all series reported.

Since survival at five years after resection is diminished to a range of 5-7 percent in the presence of mediastinal involvement, mediastinal exploration or mediastinoscopy is pertinent to the question of operability versus resectability. In contrast, greater than 40 percent survival has been found at five years for patients who have lesions without lymphatic metastasis or with involvement limited to intersegmental, interlobar, or hilar nodes. Selectivity can reduce the number of operations performed by demonstrating mediastinal lymph node involvement in many patients with little hope of cure. Surgeons can limit their operations to those patients who have a chance for cure. Thus in several selective series reported during the past decade, five-year survival of patients undergoing resection shows improvement over unselective series reported from 1935 to 1960.[6] Improving the total salvage rate of all patients is difficult. Cancer of the lung remains a lethal disease.

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Summary

Superior mediastinal spread in 59 percent of cases of carcinoma of the lung was considered evidence of inoperability, and unrewarding thoracotomy was avoided in 46 patients. Twenty patients in this series were considered operable, and six remained free of disease 2-5 years post-surgery. With this technique the resectability rate was 90 percent. False negative mediastinoscopy resulted in superior mediastinal spread identified at the time of thoracotomy in two patients (11 percent).

Thirty percent of all cases considered operable have no evidence of recurrent disease. Seven percent of all patients in this series with carcinoma of the lung were free of disease 2-5 years post-surgery.

The diagnostic and prognostic operation of anterior cervical mediastinoscopy is safe and simple and a valuable tool in the diagnostic armamentarium. Thoracic surgeons should consider it in evaluating those patients who will benefit from thoracotomy and curative resection.

Mediastinoscopy's current role in the management of lung cancer may change in the near future. Tumor debulking procedures combined with chemotherapy and immunotherapy already are beginning to alter survival rates of patients with inoperable lung cancer as judged by mediastinoscopy in selected series. □

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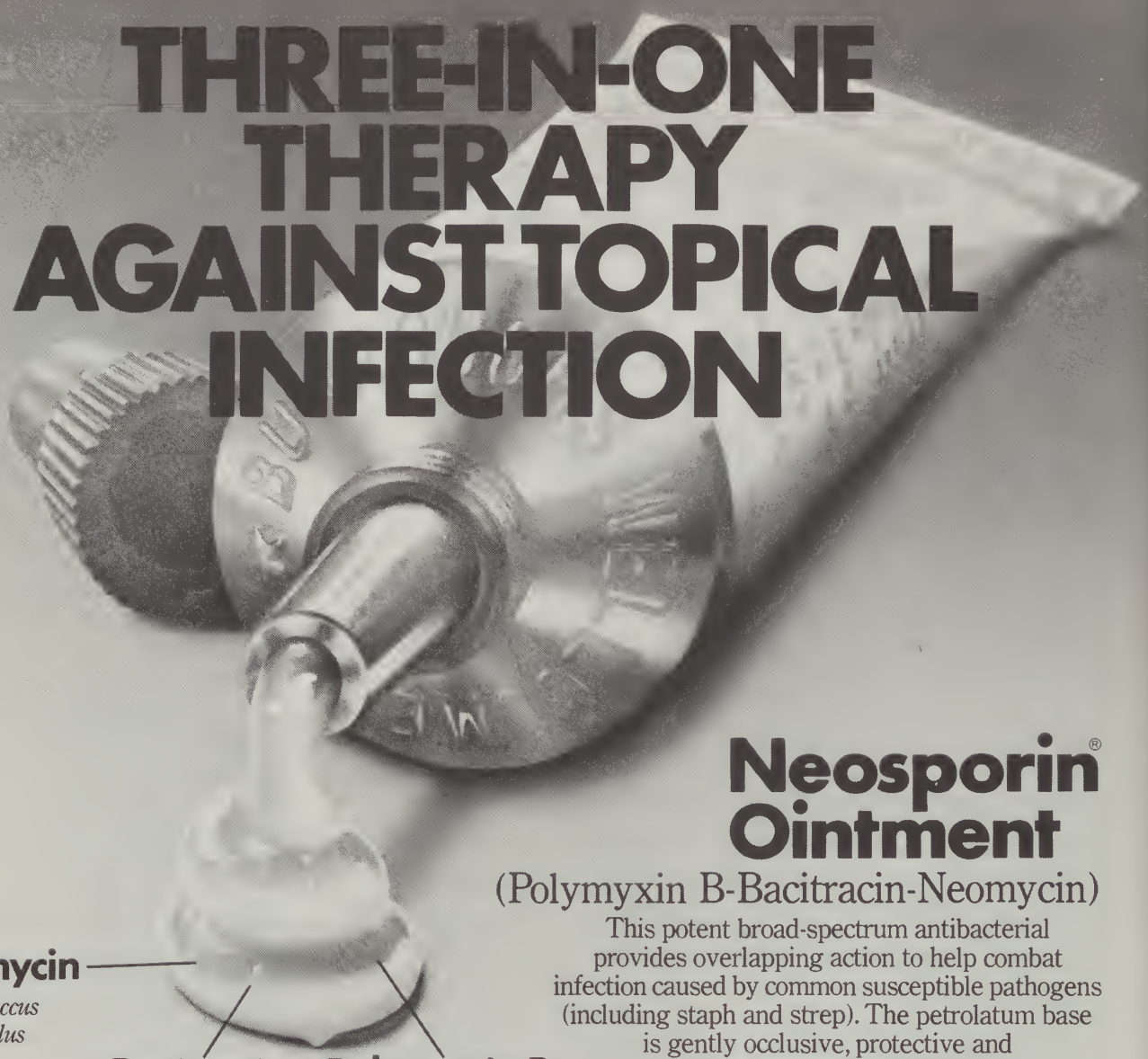
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Physicians: 'comfort always' but remember

Iatrogenic addiction no less devastating because it's legal

Abraham J. Twerski, M.D.

Many people are initiated to the use of addicting substances by the legitimate prescription of well-meaning physicians. Dr. Twerski thinks the consequences of such addiction are no less devastating than those in the drug subculture.

Early in the course of our medical training we were advised that, as physicians, it would be our fortune "to cure sometimes, to comfort always." This is and should remain the credo of every physician, but I believe there is need for some elaboration on the latter part of the axiom.

Working in treatment of addictive conditions, I have become aware of the large number of persons whose initiation into the use of addicting substances came about not by street drugs but by legitimate prescription by well-meaning physicians. The consequences of this addiction may be no less devastating than that occurring in the drug subculture.

Take, for example, the case of a 45-year-old upper-level business executive who finds his capacity to function seriously impaired by consumption of twenty Percodans daily, plus several capsules of a hypnotic drug for sleep. He is now confronted by a crisis wherein his superiors question his ability to remain in a responsible planning position in a major corporation, and whose suspicions will hardly be relieved when he takes a five- or six-week leave of absence to withdraw from the drugs and begin intensive therapy to strengthen his adaptability for coping without recourse to mood-altering medications.

The referring physician, who had three years earlier prescribed the analgesic for severe recurrent headaches and the sedative for insomnia and who expressed a feeling of responsibility for the addiction, certainly was not aware that his efforts to provide relief from distressing symptoms would result in jeopardizing the man's career. It behooves us, therefore, to take a careful look at the use of these medications, and I believe it will be helpful to consider the subject from three aspects: substances, indications, and persons.

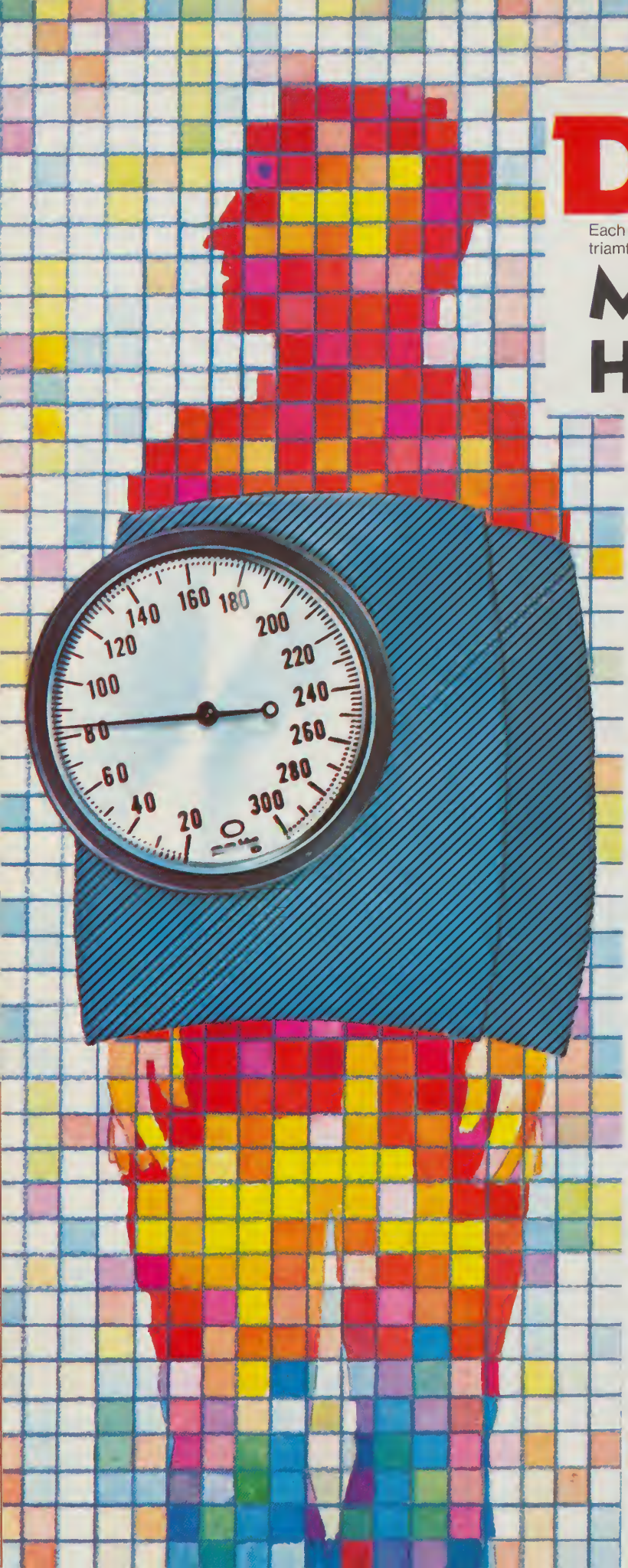
Substances

It can be categorically stated that psychological dependence or habituation can occur with any drug, regardless of its pharmacologic effects. I have known persons who were unable to function without use of massive doses of ascorbic acid or aspirin. While these drugs have no mood-altering effects and induce no physical withdrawal signs after cessation, the person can develop a feeling of anxiety or panic when they are discontinued. In these instances, habituation or dependence is apt to be on medication *qua* medication rather than on any pharmacological effect of the substance. One man, for example, panicked when he ran out of his tranquilizers and began taking his wife's Premarin. Although the use of a pharmacologically inert substance may do no physiological harm, it is cause for concern because it indicates a psychological need for which the person is utilizing an inappropriate adaptive mechanism.

Drugs that have mood-altering or sedative effects generally are capable of causing physical as well as psychological dependence. Most commonly prescribed tranquilizers (e.g., diazepam, chlordiazepoxide, meprobamate, etc.) and virtually all hypnotics (e.g., methaqualone, glutethimide, methyprylon, barbiturates) are addictive drugs in the true sense. Persons who have taken larger doses for a period of time develop tolerance to them and, when discontinued, can have full-blown withdrawal reactions, with classic delirium tremens and grand-mal seizures.

Too often new tranquilizers or seda-

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Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K+ frequently; both can cause K+ retention and elevated serum K+. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine.

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tives hit the market with claims that they are not habit forming; when wider use proves this to be untrue, the unwary physician may retain a false sense of security from the initial impression of safety. This is particularly true of analgesics. Remember that heroin was initially promoted as a non-addictive substitute for morphine!

In more recent years, there have been many cases of addiction to pentazocine, which was thought to be free of addictive properties. We should have learned enough from past experiences to consider every tranquilizing, sedating, or pain-killing drug as potentially addicting until years of experience prove otherwise.

Indications

It might appear that indications for use of these substances are relatively simple: tranquilizers for anxiety, hypnotics for insomnia, and analgesics for pain. This is simply not true. It is an excellent philosophical position that the physician should intervene *as physician* only in the presence of illness.

Various feelings of discomfort which are not manifestations of illness may occur in daily life, and there is generally no justification for prescribing medication in such cases. For example, a woman who is grief-stricken by death of her husband may not wish to eat, may cry, and may not be able to sleep well. These are manifestations of normal grief and sorrow, and are healthy responses to a personal loss. The physician has an important role as a sentient, empathic human to provide whatever personal comfort and support he can, but this is no time to administer chemicals that will numb painful but normal feelings.

A person may be anxious because of a challenge at work, for example, and this anxiety may be very appropriate. Contrary to what the TV commercials say, one should *not* take a drug simply because one's nerves are "just a little edgy," or because one cannot fall asleep within fifteen minutes. The physician must be able to distinguish normal anxiety from pathological anxiety. A drug is not an appropriate method of dealing with normal anxiety, anymore than it is of dealing with normal hunger or thirst.

The physician must be able to distinguish normal anxiety from pathological anxiety. A drug is not an appropriate method of dealing with normal anxiety, anymore than it is of dealing with normal hunger or thirst.

Pathological anxiety is indeed an abnormal phenomenon, and can be diagnosed when there appears to be no real cause for the occurrence of anxiety, for example, when the patient complains of anxiety attacks occurring "out of the blue," or on being in a room with the door closed, or on entering among a crowd. Here we must question whether the tranquilizing medication is the appropriate treatment.

We would all sharply condemn administration of morphine to a person with severe abdominal pain, for although the pain would be relieved the patient would likely go on to perforation or infarction of a viscus. Pain-killing medication may be used after a diagnosis has been established and definitive treatment planned, as when the physician has diagnosed acute cholecystitis or while the patient awaits surgery for acute appendicitis. However, analgesics that simply remove pain may conceal symptoms and permit progression of pathology to disastrous consequences.

Pathological anxiety, too, is an indication that something is wrong, and simply covering up the symptoms without doing something to correct the pathology permits it to progress undetected with detrimental results. Like morphine, tranquilizers may have their use for symptomatic relief while appropriate steps are being taken to treat the underlying illness, but not otherwise. In a word, where normal anxiety exists, tranquilizers are not indicated because they are not needed, and may actually inhibit the person's constructive adaptation. In pathological anxiety tranquilizers are not indicated because they are inadequate treatment *unless* they are part of a comprehensive therapeutic plan.

Tolerance is a phenomenon as immutable as the law of gravity. There may be individual variations of time and degree of tolerance development, but with most tranquilizers and virtually all hypnotics and potent analgesics development of tolerance is unavoidable. The question the physician must ask himself in prescribing these drugs in response to a patient's complaint is, "At what point do I plan to discontinue this drug?" If he cannot see an end point, he should be most cautious about beginning.

The physician who prescribes a narcotic for the pain of acute cholecystitis, for example, knows that the attack will run its course after several days and there will be no need for extended use of the drug. However, if the patient presents with a complaint of recurrent severe headache for which no cause can be demonstrated, there is no reason to think there will be a lesser need for an analgesic in one month, or six months, or one year. Because patients develop tolerance to potent analgesics, dosage must be increased to obtain the same effect, and it is these patients that present serious addiction problems.

The same is true of insomnia. Unless the physician has adequate grounds to assume the patient's sleep will somehow improve within a brief period of time, prescription of hypnotics is an invitation to addiction.

The physician may be placed in an uncomfortable position by the patient who insists on relief of symptoms via medication. Yet is the physician's duty to treat the illness, not to respond to patient's requests when they are not medically justified. If the physician feels ill at ease because he cannot satisfy the patient, then the prescription of the medication is to make the physician more comfortable rather than to help the patient.

We have all experienced the sense of frustration when a patient says, "Doctor, I am continuing to have trouble, and you are not helping me." I sympathize with physicians who find themselves in a position in which they must say, "My examination and tests have not revealed any condition which I can treat, and I am sorry that I cannot help you." Many patients believe that the physician is a magician, if not God-like, and must be able to do something.

Sometimes our own personality problems result in feelings of omnipotence which make it difficult to say, "There is nothing I can do for your discomfort." However, we should not prescribe addictive substances because of our own needs, but only because of the medically established needs of the patient. We all condemn the unscrupulous physician who sells a narcotic or sedative prescription for monetary gain. Is it any different if he prescribes the substances because of his own sense of frustration at being unable to find a condition which can be definitively treated?

Many physicians are adept at comforting a patient by reassuring him that serious organic pathology is not present, that some distressing symptoms diminish and clear after a period of time, and that the apparently easy solution of using potent medications for symptomatic relief carries with it a high risk of addiction.

Some physicians are able to explore other factors of the patient's life which may be etiologic in formation of the symptom, and thereby provide an invaluable psychological therapy. Due to time limitations in a busy physician's schedule and the refractoriness of some patients to accept reassurance, some patients will be unsatisfied with these approaches. Nevertheless, even in these circumstances there is no justification for subjecting the patient to a risk of addiction.

There are conditions in which the physician may knowingly addict the patient. Persons with incurable malignancies may, of course, justifiably be addicted. I have as a patient a 70-year-old male who was a chronic abuser of alcohol and sedatives. Efforts at maintaining him drug-free failed, and I then advised the patient (by certified mail) that I would prescribe his medication with the condition that he take the medication only as prescribed, and that any use of alcohol or medication other than as prescribed would terminate my relationship with him. He is seen at the office every two weeks and is given unrefillable prescriptions each time for a small amount of sedative medication. His records document exactly how many pills he has received over a period of time. He reports to work daily, and I have reliable reports from a cooperative family that he is not receiving medication from any other source, legitimate or illegitimate. Under these conditions, I am knowingly maintaining this person in addiction. Iatrogenic addiction, where the physician unknowingly contributes to the patient's drug problems, is to be condemned.

We condemn the unscrupulous physician who sells drugs for monetary gain. Is it any different if he prescribes them out of frustration at being unable to uncover a treatable condition?

Persons

Finally, the person. There is one group that must be considered exceedingly high addiction risks. These are people who have a history of previous addiction to any drug, and most commonly alcohol. Ethanol is a sedative drug, and a person who has abused or become dependent on alcohol will generally do the same with any other sedative or tranquilizing substance. Patients who are dependent on alcohol may request that they be given "something for nerves" so that they can stop drinking.

Medical treatment for alcohol withdrawal, if not done in a hospital, should be carried out with utmost caution at home and drugs should be administered only for the duration of the withdrawal. These patients cannot safely be given a substitute substance for alcohol beyond the immediate withdrawal phase.

In addition to consideration of the medical issues, the physician must also be concerned about medical-legal aspects of this problem. An attorney was hospitalized after suffering several grand-mal convulsive seizures, and it was subsequently established that these were a result of his withdrawal from chlordiazepoxide. The history revealed he had been a regular drinker and, at his wife's insistence, consulted a physician for treatment of alcoholism. He advised the physician that he would be able to abstain from alcohol if there were something to keep him from having the "shakes." The physician prescribed chlordiazepoxide, 25 mg t.i.d., and made no referral for counseling or participation in an alcohol recovery program. The patient found that this dosage was sometimes insufficient, and gradually progressed to a total of 150 mg daily. After several months he went with his wife on vacation, but forgot to take his medication along. On the fourth day, he had two grand-mal convulsive seizures.

Upon realizing that his seizures were a phenomenon of withdrawal from chlordiazepoxide, the attorney threatened to sue the physician for malpractice. His statement was, "I entered the doctor's office addicted to alcohol, and left there addicted to alcohol plus this other stuff." The prescription had been refillable, and the patient claimed he had no knowledge that the medication could be addicting.

In summary, then, we must carefully re-examine our commitment "to comfort, always." We must certainly exhaust every possible way of safely comforting persons in distress. The person suffering mental or physical pain generally desires immediate comfort, and may be seeking a simple solution to a difficult problem. As physicians, we must be wary of falling into the trap of looking for simple solutions to very complex and difficult problems. □

Court decision may extend statute of limitations

Fred Speaker, Esq.

Despite its success on the playing field, the Philadelphia Phillies team has lost a big one. A decision, filed June 5, 1978 by the United States Court of Appeals for the Third Circuit in the case of *Bayless v. Philadelphia National League Club,* has held that the statute of limitations period in medical malpractice cases runs from the time a patient knows or reasonably should know the *cause* of the injury.

The patient, Patrick Bayless, began his professional career as a pitcher for a Phillies' minor league team in 1966. Five years later he began to experience severe pain in his back and right leg, and he was treated by the team physician with massive doses of Decadron, Xylocaine, and Butazolidin. His pitching grew worse, and later that season the Phillies released him.

Soon thereafter he collapsed; in September 1971 he developed a severe depression and acted erratically, leading to confinement in mental institutions on several occasions. His diagnosis as a paranoid schizophrenic, a condition he claims was started by the drugs he was given, led him to sue the Phillies for damages. He started suit in 1976, more than five years after having been given the drugs, more than three years after having been discharged from a state hospital as a paranoid schizophrenic, but less than two years after he learned the cause of that condition.

The trial court, relying on the Pennsylvania statute that provides:

> Every suit hereafter brought to recover damages for injury wrongfully done to the person . . . must be brought within two years from the time when the injury was done and not afterwards. . . . [12 P.S. §34]

ruled that the time started running the moment the patient knew of his mental illness. The federal appellate court reversed this decision, holding the statute of limitations would begin running only when the patient knew of the injury and what caused it:

> If common sense and reason dictate that the limitation period is not to run at least until a plaintiff knows that he has been hurt, see *Ayers v. Morgan,*[1] then it should not run until he can reasonably determine what or who hurt him. Ordinarily, the two events will occur simultaneously, but this need not always be so.

The appellate court began its analysis with a consideration of the *Ayers* case, in which it had been determined that the statute of limitations period began with the discovery of a sponge left in the patient's body nine years before. It then turned to the holding in *Irrera v. Southeastern Pennsylvania Transportation Authority,*[2] which stated that the period began to run upon discovery "of the negligence or its causes."[3] The federal appellate court, however, apparently based its decision on the holding of another federal court[4] which found that the statute began to run when the patient should have learned facts that bore some causative relationship to the injury.

The decision in the latest Phillies case is potentially disturbing. It can be interpreted as greatly extending the statute of limitations beyond the traditional two years. Its development should be carefully monitored.

Mr. Speaker is a partner in the law firm of Pepper, Hamilton & Scheetz, which serves as the State Society's legal counsel.

1./ 397 Pa. 282 (1959).
2./ 231 Pa. Super. 508 (1974).
3./ Id. at 520.
4./ Gemignani v. Philadelphia Phillies National League Baseball Club, Inc., 287 F. Supp. 465 (E.D. Pa. 1967).

Parents recover damages for birth of mongoloid child

There is no tort of "wrongful birth" in Pennsylvania, but parents may recover damages for the birth of a mongoloid child. This was the holding[1] of a state court in Philadelphia this past summer.

The case arose after the mother, fearful because of prior family history, underwent an amniocentesis to determine whether the fetus she was carrying had a genetic defect known as Down's syndrome. The defendants, a physician and a hospital, reported that the results of the amniocentesis was normal, the mother had no abortion performed, and the child was delivered with Down's syndrome.

The Court held that the child had no cause of action, that the defendants owed no duty to the unborn child, and that there was no causal link between the injuries alleged and the legal theory of damages proposed. The Court reviewed two New York cases, distinguishing one[2] because in that case the defendants actually physically injured the fetus, and disapproving of the other[3] because it erroneously stated that there is a "fundamental right of a child to be born as a whole functional human being." The Court stated:

> The traditional theory of damages in a tort case is made on the basis of a comparison between the position the minor plaintiff would have been in, had the defendants not committed the act causing the injury, and the position in which the minor plaintiff presently finds himself. Applying this rule to the case at hand we are left comparing whether nonexistence is preferable to life with Down's syndrome genetic defect. Such a comparison is a logical absurdity and is not actionable at law.[4]

With respect to the parents' claims, however, the Court held that there was liability, denying several assertions by the defendants, including the

absence of proximate cause and that the cause of action would violate public policy. The Court considered two other Pennsylvania cases[5] and then stated:

> Another assertion by defendants is that such a cause of action would violate public policy. First, it is argued that such an action would encourage abortions of all borderline fetuses and second, that this would encourage societal attitudes of genetic purity. To the first position we answer that under *Roe v. Wade, supra,* the decision to abort is entirely left to the mother, with certain limitations. A doctor's role in this situation is to provide the mother with proper medical care in aiding her in her decision. Defendants' fears that doctors would abort all borderline cases in an attempt to immunize themselves from lawsuits such as the one at hand is misplaced. A doctor, in a case such as the present one, need only maintain a standard of reasonable medical care in supplying a mother with sufficient medical information to aid her in her decision . . . With respect to defendants' second contention, we simply note that as long as the mother's decision to abort is protected by the constitution, we are powerless to consider whether her decision is guided by genetic purity or not.[6]

There was no decision on the amount of damages to be awarded since the Court stated its belief that a trial judge could determine the proper elements of damage with examination of the full evidence of the case.

1./ Hartmann v. Jackson and Jefferson Medical College of Thomas Jefferson University, 1 P.C.R. 227 (1978).
2./ Shack v. Holland, 89 Misc. 2d 78, 389 N.Y.S. 2d 988 (1976).
3./ Park v. Chessin, 88 Misc. 2d 222, 387 N.Y.S. 2d 204, modified, 400 N.Y.S. 2d 110 (1977).
4./ Hartmann v. Jackson and Jefferson Medical College of Thomas Jefferson University, supra at 235.
5./ Gildiner v. Thomas Jefferson University Hospital, C.A. No. 75-3578 (E.D. Pa. filed May 26, 1978); *Speck v. Feingold,* No. GD 76-07752, (Court of Common Pleas of Allegheny County filed July, 1976)
6./ Hartmann v. Jackson and Jefferson Medical College of Thomas Jefferson University, supra at 233.

Academy of Pediatrics announces new program

The American Academy of Pediatrics, with over 15,000 members, has announced a national program to "cause consciousness-raising across the American community concerning the total health and welfare of all its children."

Saul J. Robinson, MD, president of the AAP, said the effort is called Speak up for Children! The program will begin in January 1979, designated by the United Nations as the International Year of the Child.

The national program will seek to make use of volunteer pediatricians to educate the public about child health issues. While the program hopes to increase awareness about the full range of issues affecting children, it focuses most heavily on four subject areas:

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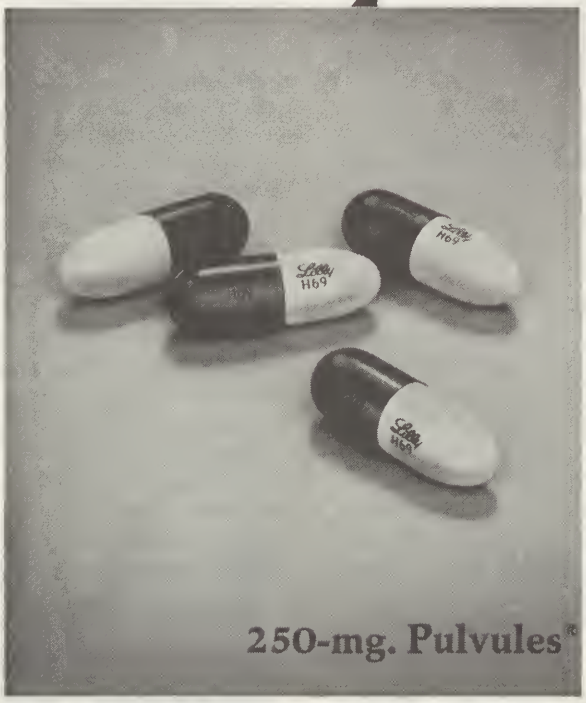
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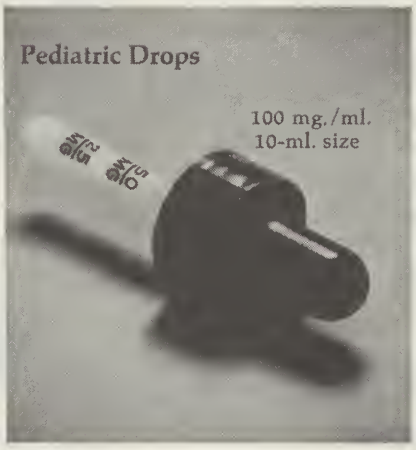
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'We should be doing both'

The "safe-cigarette" controversy that has recently made the headlines has skyrocketed a little known NIH researcher, Gio B. Gori, PhD, to fame—or infamy—depending upon your point of view. His report has won cautious approval from some and absolute opposition from others. Surprisingly, the American Cancer Society voiced cautious approval. After first warning that there is no such thing as a "safe cigarette" the Society commented, "Switching from high tar and nicotine cigarettes is at least a small step in the right direction for those who continue to smoke." Conversely, the surgeon general, the director of the National Cancer Institute, and the director of the National Heart, Lung and Blood Institute decidedly opposed the report. Julius B. Richmond, M.D., surgeon-general and assistant HEW secretary stated, "There is no known safe level of smoking of any cigarette of any type. No one should be misled by Dr. Gori's study into the belief that there is some way that one can adjust one's smoking habits and the cigarettes one smokes and thus *avoid all health risks*. Stopping completely, on the other hand, has a dramatic beneficial effect."

Some people have alleged that political haymaking was involved in the release of this federally funded research, especially since the government subsidizes the tobacco industry and may welcome an escape from this tight situation. While that may be true for others, Dr. Gori has remained firm regarding the conclusions of his study, which he believes has been misconstrued. "Out data have been misinterpreted. What we are saying is that when the new low-toxic cigarette brands can reduce the risk of mortality among smokers so that it is less than two-to-one in relation to non-smokers, then the difference in mortality rates may become epidemiologically undesirable. This means that the habit may become tolerable from a statistical standpoint."

Dr. Gori also has been misquoted. Nowhere in his paper, which appears in the September 15, 1978, issue of the *Journal of the American Medical Association* does he refer to cigarettes as safe. Neither does he say that by switching to low tar and nicotine cigarettes that all risks will be avoided. What his paper really says is that we have developed less hazardous cigarettes than the pre-1960 era and that we have the technology to even further define and reduce the toxic constituents of cigarettes. His conclusion that a move to less hazardous cigarettes may have the potential to reduce smoking-associated diseases, may have some merit. Simply to reject the study as unacceptable because it does not reiterate the approved conclusions and opinions is absurd. To misinterpret and misquote the material based upon emotional reaction and without proper study is to compound the absurdity.

This is not the first paper that Dr. Gori has produced on the subject of less hazardous cigarettes. A similar one appeared in the December 17, 1976, issue of *Science,* entitled "Low Risk Cigarettes: A Prescription." In the two years between publications, neither the message nor the conclusions have changed radically. Although we have had anti-smoking campaigns, a large number of Americans continue to smoke. By removing toxic constituents from cigarettes and by reducing the total intake of smoke, the risk of smoking-associated disease for smokers possibly may approach that of non-smokers.

Dr. Gori has been quoted, "I do not see why we should have to choose between educating against cigarette smoking and developing a less hazardous cigarette. We should be doing both." And further, "I am not advocating that people should smoke. The only totally safe cigarette is a cigarette that is not lit."

Tobacco is a vice in which man has indulged for some 500 years. It is not an easy habit to break, as anyone who has ever been "hooked on the weed" will tell. It just may be that less hazardous cigarettes are a partial answer. It may also be that they are not.

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DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy,* Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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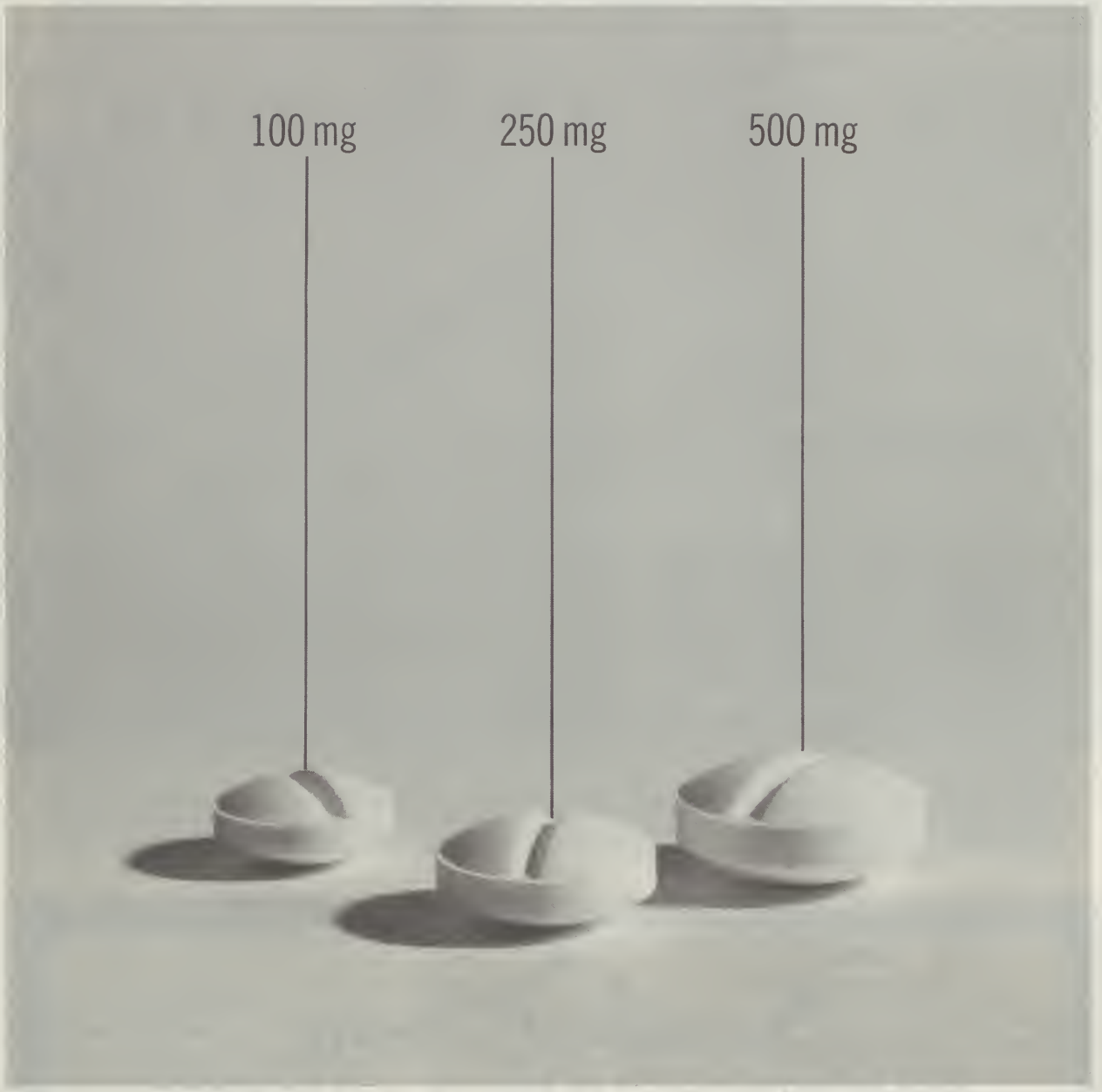
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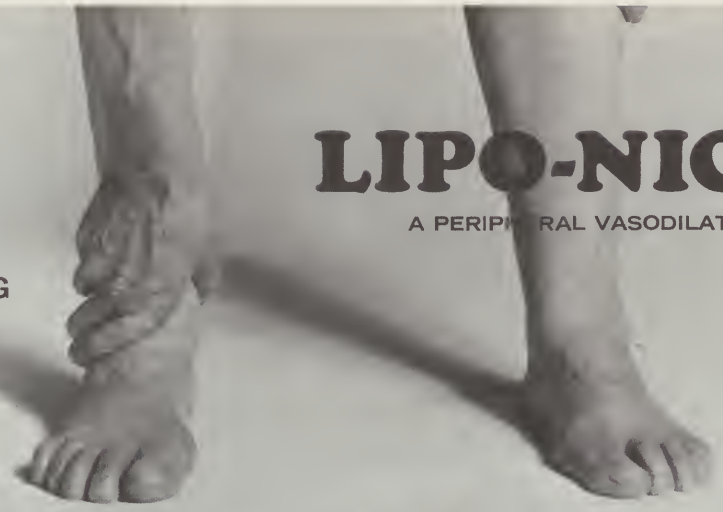
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Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

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Recommended dosage for children—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. A guide follows:

Children two months of age or older:

Weight		Dose—every 12 hours	
lbs	kgs	Teaspoonfuls	Tablets
20	9	1 teasp. (5 ml)	½ tablet
40	18	2 teasp. (10 ml)	1 tablet
60	27	3 teasp. (15 ml)	1½ tablets
80	36	4 teasp. (20 ml)	2 tablets or 1 DS tablet

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	½ the usual regimen
Below 15	Use not recommended

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